

# An Exploration of Parent/Teen Relationships

David VanNuys, Ph.D. interviews Michael Ocana, M.D.

David: My guest is today is Dr. Michael Ocana, and we'll be discussing his work with troubled teens. Michael Ocana, M.D., is the program medical director for the adolescent psychiatric unit at Kelowna General Hospital in British Columbia. Dr. Ocana also consults to youth in crisis at Kelowna General Hospital in the emergency room, the pediatric ward, and sees youth in crisis through an urgent response program to prevent hospital admissions.

In addition he consults to an outpatient eating disorder program for patients of all ages and has a small private practice. Dr. Ocana completed medical school at the University of Ottawa in 1997. After completing an undergraduate degree in psychology, he went on to complete his psychiatric residency program at the University of Toronto, specializing in children and adolescents.

During his residency, Dr. Ocana pursued specialized training in neuropsychiatry, publishing a paper on mild head injury in addition to pursuing psychotherapy training and interpersonal psychotherapy, cognitive behavior therapy and psychodynamic approaches. In addition to his clinical and administrative work, he's been providing education to the public and to mental health practitioners through the Canadian Medical Health Association.

Some of his talks are available online on topics from eating disorders in youth to adolescent depression and suicide. You can find some of those on Vimeo and you'll also probably find links on his blog which you'll find at [teenshrink.blogspot.ca](http://teenshrink.blogspot.ca). Dr. Ocana has special interests in attachment theory, culture and neuro-development, and over the past two years has published an online blog titled Teen Shrink Talk, where he explores and reviews issues in neuro-development culture, attachment and mental health as they evolve through the lifespan.

Dr. Ocana has recently begun training in the modality of somatic experiencing, a therapeutic approach pioneered by Peter A. Levine, and is scheduled to become fully accredited by the fall of next year. Now, here's the interview.

Dr. Michael Ocana, welcome to, Shrink Rap Radio.

Dr. Ocana: Thank you, David. It's a great pleasure.

David: It's a real pleasure for me because you and I have had a lot of communication back and forth. You are a faithful ShrinkRap Radio listener, and I feel like we're friends, and if we've lived closer, that we would in fact be friends and hang out.

Dr. Ocana: That's great, David, I feel the same way. I've enjoyed listening to your show tremendously, so it's a great privilege here to be able to talk to you like this.

David: Yes, well likewise. Now, I know that the focus of your work as a psychiatrist is that you work with troubled teens in the inpatient setting. What drew you to specializing in working with teens?

Dr. Ocana: That's an interesting journey for me. I went to psychiatry which was the specialty selected at medical school. That journey was one, I was actually trying to fit in a number of things including neurology, but I found psychiatry to be something that really appealed to me. When you are working in medicine you have to go a little bit against the grain in a way it is not, it is sometimes called the ugly step child of medicine, psychiatry.

You have to go a little against the grain when you go there, but that really drew me. I found it fascinating and so much more interesting and rewarding for myself, so I found myself in psychiatry. Then, within psychiatry to get another process of selecting where you are going to end up, and somehow I always get drawn to the most complicated thing. I found working with children and families just intriguing.

I wanted to learn more because it was difficult to understand, and it was more complicated and I found it sometimes the most complicated area. I ended up here and working with adolescence and families, that's what I do and yes I enjoy it a lot.

David: Well, that's a good reason. I am glad you shared that background with us and that's part of the focus that I want to have in our interview today is just how do you communicate with teens, how to parents, how to psychotherapists and so on and we will be getting into that. Of course I have to wonder what were your own teen years like and whether or not that might have had something to do with your career choice?

Dr. Ocana: Well, that's a great question David and I have heard you explore that here on your show with others. My teen years were interesting. My parents are immigrants from Europe and I was born in Canada. All my extended family remains in Europe, almost all. They came to Canada in those really complicated years that followed World War II.

David: From where?

Dr. Ocana: From Spain and Germany. My father was from Spain. I have a broad family base still back there in southern Spain and my mother from Germany. I have an extended family there in Germany. They got together somehow, somewhat of a cultural, interesting, coming together, and so I grew up in the suburbs of Toronto. It is a pretty big city up here in Canada. It is the biggest city in Canada. I think I found it alienating. Interestingly, my parents ended up in a neighborhood that was culturally really quite different. Interestingly, we had a Hasidic Jewish neighborhood. Well, it became Hasidic Jewish neighborhood. It wasn't really when they moved there. I was surrounded by a very different culture, as you can imagine.

David: Wow, yes.

Dr. Ocana: Yes, so it was complicated. I found it hard to find a place. I did in the end. It became a bit of a tumultuous experience for myself going through phases of probably little bit too much alcohol use and things like that. I somehow managed to stay afloat and have my own adjustments, which came a lot more during my early adulthood where I found myself having to get psychiatric help for a period of time and came through that.

It was powerful experience for me, very meaningful and very complicated, but I managed to keep my ship afloat, get through medical school and here I am.

David: Well, did your experience with psychiatry at that time impact your subsequent choice to go into psychiatry? It sounds like it was positive for you.

Dr. Ocana: Yes, I mean, I am not sure my experience with psychiatry was positive, but the whole experience was powerful and meaningful to me, so it clearly held a fascination. It makes you curious about that area and want to know more and it leads you, I guess. What you think about it is you want to understand your own experience. It is fascinating, so yes certainly it drew me there, and I guess I got through it in a way that I was curious and I wasn't afraid of it.

David: Okay.

Dr. Ocana: Certainly, yes.

David: I understand that you are currently in charge of an adolescent psychiatric unit, so tell us a bit about that.

Dr. Ocana: Right, I am here in British Columbia, Canada, and in a moderate size city, about 200,000 population, and there is a hospital here that I connected with. There are a few other child and adolescent psychiatrists when I arrived here right out of training. I did my training in Toronto, so I got here and I started out my practice.

They were developing an adolescent psychiatric unit here at the hospital and so they asked me if I want to take part in that.

I was quite interested to do so and we started this unit up, an 8 bed unit to serve the area here and we really wanted to try something that is different from the traditional psychiatry model, and so from the get go we started with a different approach to working with young people. I don't know if you heard of Ross Greene, Dr. Ross Greene, a psychologist in the United States who wrote a number of books on working with children. He had a famous book called, The Explosive Child, which always makes people think that the child is actually blowing up somehow like a bomb.

David: I have not heard of him or that book but The Explosive Child certainly reminds me of, and I am going to forget a lot of things, but when I was in graduate school I worked at a place called The Fresh Air Camp for emotionally disturbed boys and we had a lot of explosive kids there.

Dr. Ocana: Yes, so you know what it means.

David: That really resonates.

Dr. Ocana: Exactly, his work there, when I was going through my training I came across it in a number of settings which I mean it was interesting because it really contradicted the other main approach that people were often being directed towards, you might have heard, one, two, three magic or the timeouts, all that things.

David: I haven't heard of the one, two, three magic but I certainly have heard of timeout.

Dr. Ocana: Right, and so that's a very different approach. I remember going through my training, I would say here watch this video, one, two, three magic. This is how we direct parents to work with your children and help them with discipline so the approach is very behavioral.

David: That's what I was guessing, yes.

Dr. Ocana: Yes, exactly, it is all about rewards and punishments and it comes from that entire area of psychology and mental health, the practice of behavioralism, right?

David: Sure.

Dr. Ocana: Many psychiatric units have that as their guiding principle of what they call milieu or behavioral control or management or whatever you want to call it.

David: Right.

Dr. Ocana: Where kids earn rewards or receive punishment more or less or loose privileges, you probably heard about the privilege system?

David: Sure.

Dr. Ocana: That's very awesome. I had done some research in the literature on avoiding seclusion and restraint in hospitals because as you know it is one of the most traumatizing things that can happen to anyone when they end up in the hospital. It happened to me when I was in the hospital, where you end up being retrained and secluded, a very, very stressful experience.

What they found is that one of prime triggers for that situation unfolds with young people in the hospital, is that they have their privileges removed or they have some behavioral consequence dished out. Then it often starts the whole cascade going to that.

David: I understand that this approach that was developed by Ross Greene, who you mentioned, is called collaborative problem solving and that you have implemented that?

Dr. Ocana: Exactly, it is called the collaborative problem solving method. He consulted to our program and so basically throws this whole system of behavioral intervention guide. He uses a very different approach of working with the young people that really involves a lot more engagement and problem solving.

David: Yes.

Dr. Ocana: It is a very problem solving based method which first of all requires quite a lot more effort. It is a lot more complicated than just simply saying, oh he did something wrong, conflict. He did something right, privilege, right, and that's simpler. It takes less communication on the part of everybody communicating with one another. This system, we had a lot of good interest from our staff about wanting to work with this method.

We've had a lot of success with it. Our rates of seclusion in our hospital, it is almost never happens. Occasionally there are times when something gets very unsafe and we still have to do something like that because we are dealing with people who are very ill but it is very infrequent. It has been really rewarding that way.

That helped me to understand that communication and especially parenting, you are working with the tradeoffs in a way of how we engage with one another. The more we can work at engaging collaboration, it actually works with entire different part of our nervous system and our brain when we engage collaboratively as opposed when we engage with one another reactively.

David: Okay, well, I am going to want to go into that brain part of it a bit down the road, but before we go there, maybe you can give us an example or two, case examples from your experience of where this collaborative approach, as you say, is very challenging and yet effective.

Dr. Ocana: Okay, sure, I will try and think of a good example here. This is a case. A young person for example we have school on our unit, and we really make an effort to engage young people to take part in the school. Whereas perhaps in the traditional method you might say, if you are able to attend school you will be able to advance your privilege level, perhaps or something to that effect. You will have some certain privileges that you wouldn't have if you weren't attending school. That is very common. If you don't go to school, you get removed.

Then, what happens is the some young people won't go school. If you use that system you never really get to figure out why they wouldn't go to school. With the collaborative talking solving strategy you always start off with a curiosity which is to say, hey, what's up and tell me about what might be making it hard to go to school.

Then, you start this process of, let's work together to try and figure out what's going on here and then maybe we can find out a way that we could create a way you could be in school that would work and find out what the barriers might be. I mean, we don't deal in this language with youngsters, but in your mind you think what are the barriers for this young person going to school. Is it perhaps as he finds his teacher intimidating? Is it perhaps that the other kids make him nervous? Is it perhaps he is afraid of failing on the school work?

You are asking, inviting and engaging in collaborative questions about, hey, what is it that's really making you most nervous about being in the school. The young person often does not know. In the process of engaging them collaboratively you open up their mind that gets curious about, yes, well is it this, no, I don't think. Yes, that seems more like it, and then you might invite, hey, what if we tried this out, maybe being in a quite part of the classroom or maybe starting up by getting to know some of the other kids outside the classroom.

You can start being creative and you can create a little opportunity where they would do something that they right away they would just say no. The young people very often are not expecting you to do this. They expect you to be

frustrated with them. They expect you to start coming at them with, you got to go to school, right, or you going to tell all the bad things that are going to happen if they don't go to school.

They are really surprised very often and then it depends a little on their background when you engage that system and then you start to think of, then you can find more about what is actually going on with this young person that might be getting in the way. Before, you wouldn't have that information. It helps you learn more about it. It is an assessment tool from our point of view but it also allows the new development to happen that might not otherwise.

David: Let me just comment. I think curiosity is a very powerful concept. Interesting that curiosity plays such an important role there. It certainly flies in the face of thinking of oneself as a therapist, as a psychiatrist, as the expert, as the person who has all the answers and comes in with that kind of an attitude. My own experience with curiosity is one, I have some background in market research as listeners may know, and the guy who trained me in that really emphasized the importance of curiosity. When you are working for a company, a client and they are trying to find out something about people's attitudes towards a product or a service, to really be curious about everything around that. I think that training and that orientation really has also informed my approach to interviewing on ShrinkRap Radio.

Dr. Ocana: Right.

David: Then the other thing that I would note is, a therapist that worked with me for a while, her most outstanding characteristic I would say was her curiosity. I think what curiosity ends up being is a sort of highly amped up interest in me. She just seems so interested in every little detail of my life and of my thoughts and so on. She was greatly loved by many, many clients, and I think just that level of attention to detail and curiosity communicates a deep level of caring.

Dr. Ocana: And acceptance, right?

David: Yes.

Dr. Ocana: It is an acceptance that no, this could be okay.

David: Yes.

Dr. Ocana: It would be okay if you are finding this difficult or that difficult so all of a sudden and it turns on a different pathway and in the energy in the relationship which can be quite stabilizing and can lead to positive change.

David: Is there anything in this approach that might be useful to parents with troubled adolescents living at home?

Dr. Ocana: Yes, absolutely, because many parents didn't experience this engagement in their own upbringing or in any other intervention or in any of the advice that they are given by people who give parenting advice. I remember being very stuck by this, wow this is completely different than this other one, two, three, magic thing, I mean. There was all the clarity, which is important too to have this in place and so that is the advantage.

You need to be super clear in certain situations rather than how do we conserve energy. We don't have all the energy to manage every single situation in this way but for parents who have the resources to start this process up, it can really, really make an amazing difference in their relationship with their youngster who is having problems, because all of a sudden they become partners in overcoming these problems rather than adversaries in like, you know you screwed up again.

You get into this negative cycle of groundings or whatever it is, right, you lose this, you lose that. The next thing you know the kids have nothing left. Everything is going to be removed and now they are really, the parents think now what do we do. We have lost everything. We have no more leverage.

David: You are a parent yourself, right.

Dr. Ocana: Right, yes.

David: Remind me, how many and what ages.

Dr. Ocana: Okay, two youngsters, I have an 11 year old, just turning 11 boy and a girl who is going to be 9 in December. They are just starting to peek around the corner at adolescence, or at least the older one.

David: Yes, right, you really got a chance to put some of these ideas to the test...

Dr. Ocana: Absolutely.

David: With your own kids, yes, I am sure you are laying the ground work that will make it easier when you get there.

Dr. Ocana: Yes.

David: You mentioned Ross Greene's book, The Explosive Child. I don't know if that's the general purpose book for parents or is there some other book that he has



written that would be good for your average parent versus ones who are really in deep water?

Dr. Ocana: I think he has written some more recent books on collaborative problem solving which I don't have the titles of on hand here, but you can look it up. I know he also has done some things online for helping parents, even courses and things like this. Yes, there are a lot of good resources out there to help people get the idea of how this might work.

This has got this really neat advantage that it doesn't. Very often people get the idea is that we either have to engage with our kids and love them and be really receptive and accepting, in which case all of sudden it starts to sound like you can't have any expectations, which is anything goes. It starts to feel that way, where people are, if I give up the grounding I am going to lose control here. I am going to lose power. It is going to be all wishy-washy.

The really neat thing about this, the collaborative problem solving approach, is that it doesn't lose that. We have expectations. We don't drop them. You just approach them differently. It is really nice because first of all it takes a little thinking, well how does that work. How do I have expectations without these punitive consequences or the rewards with the stickers and allowance to do this. You get the allowance to do this. You don't get your allowance.

What we have learned, and there is some research that I've come across, is that when you have rewards you often lose the natural incentives, as there are natural incentives to most things, such as helping out at home, doing your homework, doing all the things. There are natural rewards. When you apply artificial rewards, like I am going to pay you your allowance based on how many dishes you washed, it takes away the natural incentive system.

Same thing with homework. A lot of people with homework may say, you do your homework you get this sticker and in week you get this. It just becomes a work. It is no longer curiosity based. It is no longer I am interested in my homework. I am doing it because I want a reward at the end of this week. It is really quite powerful when you can get away from actually dampening down people's natural ability to want to cooperate by doing that. I think I may have lost your question there somewhere.

David: No, no, this is all quite relevant, and I think before you started to say something about the brain and how, maybe how different rewards centers... This might relate to the brain, and I know you are interested in the inter-personal biology of the approach that you are describing so tell us about that. Let's go inside the skull a little bit here.

Dr. Ocana: Okay, yes, yes, great. In fact it is really important to recognize in a way that it is much more than just the skull. It is our entire nervous system, okay. Our nervous system has often been somehow relegated to the skull but it doesn't end there. What is important is that our relational interaction with one another will affect our whole nervous system? You interviewed Steven Porges.

David: Yes, right.

Dr. Ocana: He was able, in his interview there, to share with you a little bit about his discovery and his theory that he has been developing, which is now quite an advanced and well backed-up theory, that in mammals and most developing humans we have this part of our nervous system called the ventral vagal parasympathetic system which engages through the use of our face and our voice and our nonverbal communications when we give the message about safety.

When we give a message of safety like a curious, accepting message which we deliver actually nonverbally with our eyes and our voice and our tone, we engage to this nervous system which is common. It decreases the arousal, the heart rate. It changes the state. It is what you use if you going to try to hypnotize someone, those soft tones, that is the part of it. It is very powerful.

David: I seem to recall that oxytocin plays in a role in that.

Dr. Ocana: Well of course, certainly, yes. Oxytocin is part of that system which is quite fascinating. Yes in doing this, we have now changed the interaction. That opens up a different ability to think, because when we are not calm we think with our survival brain. Then we are orienting to different things and we can access different parts of our behavioral repertoire. We get defensive. You know what I mean. When the boss confronts you at work, you get defensive. Where is this thing? Then, the whole nonverbal isn't curious at all.

David: That defensive system kicks in really fast.

Dr. Ocana: Right. We lose our ability to be curious very quickly and then often with the teenagers, you will get answers like, I don't know, I don't know and the head hangs. There is no eye contact, and they are almost frozen perhaps in front of you if there confrontation with us, they start reacting with anger, which then you are really not cooperating anymore. You are now adversary or you are not solving a problem. You are in a confrontation with each other.

David: Yes.

Dr. Ocana: That's very much about our interpersonal neurobiology.

David: Where does attachment theory fit in with that or interphase with it because I think that it is all tied together in one big whole?

Dr. Ocana: Absolutely, attachment theory ties into it directly. Attachment theory explains a number of things. One of the things it explains is the development of our nervous system in our patterns of regulating our nervous system. Right from pre-birth, there is a dance going on between the child and the parents. That dance involves the nervous system, and it involves the development genetic expression, so happy genetics, which is whole fascinating area that's just coming around in the past couple of decades here.

Then, after birth this interaction broadens to include other senses. Sound, hearing, it starts before birth and after birth that become different, and then visual and learning to the face, and so obviously an infant can't regulate its own nervous system. It is not able to, but over time it may become able to regulate it, certain more and more and more independently, but never entirely independently.

None of us will regulate our nervous systems entirely independently at any point in my life, which is why solitary confinements doesn't tend to be very good for the nervous system. We always maintain some level of interpersonal regulation all the way through. Attachment is basically, how do we orient to somebody else's nervous system.

Children will orient, they will look at their parents to check something out. Is this safe, they will look, unless they are autistic which means that part of the nervous systems is not working the way it works when somebody doesn't have that problem, as the child doesn't orient to those few. Basically, they manage it internally or somehow through some rituals. The way things are going the way development goes ideally I suppose or the way it often does, they will orient one way or another.

For certain types of attachment patterns they are orienting constantly. That is the ambivalent attachment, or they orient and they remain super focused on the parents or on threats around them and just stay very clinging and sometimes reactive, trying to control their parents somehow by either care-giving them or controlling them through demands or some coercion.

There are those all kinds of different patterns that can happen, or the avoidance which does not orient and tends to orient away from the parent when they get stressed, they tend to not reach out. They tend to be quite very early trying to be more independent. Although, there is still stress, these kids may look not stressed sometimes but underneath we call them, it is a like a duck sitting on the

water, their feet underneath are moving very quickly but on the surface they look very calm.

David: I love that metaphor.

Dr. Ocana: Yes. Those are different patterns of attachments. In my last post that we talked a little bit about, I talked about how, as young people in our culture, we have some strange patterns with how things have changed in our western, what they call it, weird western educated industrialized rich and developed world, the weird culture where most of our science is based, I mean, most of our science subjects come from this culture. We don't often compare outside of it.

In our culture we really have this strange pattern, that in adolescence, adolescents are spending their time in a very much their own age group category. We send them off to school. They spend the whole day there. After school they hang out together, and sometimes they hardly come home at all. We sometimes look at that as normal, but is it? What is that due to this attachments that is still important?

David: Yes.

Dr. Ocana: I think we can start to understand, with the very big problems that we run into, how many parents who are thinking about their teens entering teenage years, you don't tend to get a lot of, oh this is going to be so easy.

David: Yes. Well I guess you know, what you are suggesting is that if all the mirroring that you get is from other under developed, undeveloped nervous systems, then it is not really that supportive or your own development and growth.

Dr. Ocana: Right, and I don't know if you have come across some of the studies on primates, monkeys or different primates, where they experiment with having them being raised in groups with adults and having them being raised in groups of only other immature.

David: No, I am not familiar with that.

Dr. Ocana: It is called peer raised. The classic studies to look at what happens if we separated monkeys from their parents, right, and then they are then they are just in the cage by themselves and they cling on to that terry cloth thing.

David: Right.

Dr. Ocana: That doesn't go well. Then the next question was what if they just, we put them a group of a whole bunch of other immature monkeys. Then, they cling on to

each other. They become each other terry cloth thing, but I mean it is better than the terry cloth monkey, mesh on the wire backdrop or whatever right, but it is still not the same as having mature others.

David: That really suggests to me. I am immediately getting a picture of a gaggle of girls at the mall.

Dr. Ocana: Exactly, yes. Now with social media where they can be in constant contact with each other 24x7, as they say, it can become a very desperate clinging through difficult times and a lot of things get quite out of regulation there. We hear of groups of young people who are all struggling and who all turn to one another to fuel themselves.

Now they are no longer attaching to adult care givers. They are attaching to each other. Call them in the middle of the night. I am having a bad time. I just cut myself. They will try to support each other desperately, just panicking. It can become, when you explore the world of these young people, a very desperate kind of situation.

David: Yes, wow. That really is a different way of looking at it, I mean. I hadn't thought of in terms of the primate behavior that you described and seeing how that might map on to a lot of what's going on with social media and so on, and I think a lot of those, there is this term emo. Are you familiar with it?

Dr. Ocana: Yes, very familiar with it, yes.

David: Maybe not everybody is familiar with it. Tell us your version of what emo refers to.

Dr. Ocana: It refers to a number of things. It is a cultural term and it basically refers to a sort of subgroup of young people. Back in my days growing up, there were the punks and the mods and the preps and the jocks. Emo has been a little subgroup, and in this group they have a hairstyle and has a certain fashions and they listen to a certain music.

They also strangely have this behavior of self-harm that came on somewhere along the way as being part of this almost fashion sense. They may have a bandana around their wrists where they cut themselves very often. As I remember this came on sometime in the early 2000 year there. I was thinking wow, like now mental health problems are almost seeming to come out as a cultural fashion, seeing this very strange mixture of a social phenomenon, if you want.

Basically, I mean, the idea comes from emotional and somehow the music was emotional, referring to sensitive, talking about how I am feeling. I got a lot of backlash from, it became almost an insult, that activity, with one other because of the vulnerability of it. You are talking about how you are feeling. We don't talk about how we are feeling. That's one group of kids beating up on another kid, as almost always happens. So yes that's my understanding of that.

David: That's good, I actually learned quite a bit because I couldn't have said all that. I note that you are in the last year of training and Dr. Peter Levine somatic experiencing approach to trauma. What is the role of trauma in the backgrounds of the teens that you work with? Is that what is motivating you to do that training?

Dr. Ocana: Well, not entirely, not in my last year. I am actually, I am in a condensed training a bit so I am still doing really the first, if you think about it as three sections, I am still at my first section. We are going to try, it is a condensed one so I should be able to get things wrapped up by the beginning of 2015. Yes, I went to the Interpersonal Neurobiology Conference again in LA last year.

I read some of Peter Levine's work before and had been introduced to some colleagues. It really is quite a different paradigm so I was like, wow that's different. When I saw Peter Levine doing his work, his friends are there and he will show his videos, I was just really fascinated with that. I was just curious. It really brings in a lot of this, what I have been talking to you about.

It really made a lot of sense to me, so I decided to go and pursue this training just to really get a sense of how this might add a deeper level of understanding, and really it is quite profound. Certainly his work came up in the idea of how the nervous system responds to trauma.

David: Yes.

Dr. Ocana: But really I don't know that it needs to end there. I mean I really think, again, the total attachment piece works with all of that nervous system as well, as well as other things that are not trauma, like grief and loss. All those same layers of the nervous system are involved in that kind of emotional adjustment where the loss is not a trauma. It is natural sometimes, right, loss is part of life.

It is not considered like the car accident, and yet it can really impact the nervous system in profound ways when it doesn't go well, and it can remain frozen in the nervous system, much like trauma can, especially when we are talking abandonment type of loss. We also don't think abandonment as the trauma. It is not an assault or a car accident, but it is quite, it is very similar because survival hinges on us not being abandoned.

David: Sure.

Dr. Ocana: Yes, in many ways I don't know we can really differential these things. I mean there are some differences. I think there are different parts of the nervous system that get lit up there but they engage the very same sympathetic/parasympathetic systems that trauma does. It is really, it is very fascinating. I am learning a great deal from going to the trainings and really doing something remarkable.

David: Well, yes, I am not surprised from what I have heard, and when I think about my own experiences with being on locked wards and so on, when you look in to the background of the people that are there you find, if not an out and out trauma, very difficult circumstances in past lives.

Dr. Ocana: Absolutely. I mean very often there is trauma, I mean very often. Yes, it is definitely, in the work that I do, very much our lives in terms of what is going on.

David: I tried to get Dr. Peter Levine to interview him, and I am going to keep trying. I have tried to tunnel in through different contacts but so far with no luck. What is it that parents need to understand about communicating with and relating to their teams, to troubles teams?

Dr. Ocana: Okay, well, I think it is pretty important to just understand that what we expected teens, in terms of managing their world, is we actually expect quite a lot of them. I think there is this myth that kids believe they have it incredibly easy. It is a rich society. We live in a rich society. We have all these things that most of us never had or many of us, certainly my parents never had these things. That is why, often it is like kids are spoiled, that they are not grateful and so on.

I mean often we lose sight of these incredible challenges that are based right from early on in their lives that probably we never did, or some of us might not have, which often are going up in communities that are really thrown together, because there is so much mobility nowadays, but they are growing up without the context of known predictable others. They go to school.

We don't know who they are interacting with. We don't know their teachers. We don't know their peers. We are basically putting them in a group of strangers, which our nervous system, I do not think, are adapted to. Our primate ancestors did not grow up surrounded by strangers. If you look at primates in general if you put them around strangers they tend to kill each other. Yes, that's what they do, yes.

David: Yes.

Dr. Ocana: You can't put a bunch of gorillas or chimpanzees or most other primates in a group of strangers without them basically fighting to death.

David: I am getting scared just hearing you describe it. I think I am being re-traumatized with going to kindergarten or something.

Dr. Ocana: It is true, right. I mean it is a very stressful thing we are doing and we don't really appreciate that. That's why there is so much separation anxiety with kids going to kindergarten and they cling on to their mom's waist, and I am very often working with kids, but that is where it started.

David: Yes.

Dr. Ocana: They got restrained by the teacher to hold them there and no, no, they will calm down eventually, just leave. They are being held by some stranger, right, very stressful on the nervous system. By teenage years the kid would numb themselves up out to that sort of but then they enter a different stage where now they have to seek their identity amongst these others that are surrounding them, some of whom will have some safety with if they are lucky, but many of them, they don't.

Then, it becomes a very intense contest for who fits in. The nervous systems of the teenager are changing to make that a paramount of importance, that now they are really being driven by new set of instructions, so you have to get out into the world now. It is time for you to disconnect, a little bit. That's natural that our attachment to our parents starts to become a little less important.

That kind of regulation within the new environment becomes so much more important. They is really a heightened sense of importance of all these other people around you and finding your safety there and if it not, if you don't find it, it can become quite stressful, until they shut down. The rates of depression of course start to go up once you enter that, as do almost every other mental health problems in the teenage years start to go up, drug use of course and eating patterns and depression and then also even more severe problems, like psychosis and schizophrenia and such.

Now, for your average parent, many times the kids start to navigating this more or less to set free, if you are lucky. They might not be and they might start to struggle and they might start to come home really moody and they might start to disengage from you in a way that doesn't seem okay. The lot of people are say, the teenagers they are just moody, not a big deal. No, they will just grow out of it.



You want to pay a little attention to it, right, and really see if you can, here is one thing that we can fall into the society. One thing you can fall into is to think, oh my god, I really hope my kid fits in. I really want to make sure they understand how important that is, and I am going to really tell them go meet some friends and buy some new clothes maybe. Make yourself you are a fit and don't embarrass yourself.

You start to give these messages that makes it even more important than it already is. That's something we could do a lot better. I think generally too, you know, let's not make them even more worried about fitting in. Let's give them some space. Maybe he doesn't have to be that important. Let's give them a secure place here where they can be safe with us and we don't look at them with disappointment if they don't have all these cool friends, or if they are acting as a geeky or nerdy or whatever ,the things that we call the kids who don't meet the norms.

Maybe it is okay for them to be in the chess club or that kind of thing and we don't have to give them that, oh god, he is going to get rejected. That's our insecurity that gets lit up when we see our kids maybe not throwing themselves into the peer world, so that is another thing to keep in mind.

David: Well, it is certainly a big topic when I ask what do parents need to know about communicating with their troubled teens, so that is the subject for certainly more than one book. Similarly, let me ask you for a thumbnail sketch of what psychotherapists, maybe psychotherapists who are not specifically trained in working with teens, what is that psychotherapists need to understand about communicating with and relating to troubled teens? Certainly everything that you've just outlined about the social and inner world of the teen is very relevant here. But what is that the average psychotherapist might not be aware of or might miss?

Dr. Ocana: Yes, that's a really great question. I think really the number one thing that I think we can all do better, many of us, maybe we haven't paid as much attention to as important, is nurturing the relationship between the teen and his parents. I think unfortunately as a discipline, we often started getting, ah these kids are messed up because their parents are messed up. We got to start dealing with this adversarial thing to protect these kids from their parents, because very often, of course with troubled teens, the parents have been less than perfect.

No big surprise. We start with this negative energy source that, your mom-she is such a problem. Your dad-oh my god is abusive. We forget that, well I mean it they are really abusive, right, it is a very serious problem. Very often teens are abusive, really they're not coping well. There is still a positive side. Maybe they yell, or maybe occasionally even physically confront.

We can get so caught up in that, that we forget, are there any values here and what is the good side of this family? What is their resilience? How do they work together? How are they committed to each other? Really think creatively about that, so you want to find that balance. You don't want to accept abuse, that's not okay. But you want to not immediately start to, because you can easily alienate kids from their own families by just how we think about it.

Very often kids already come to us alienated from their families and sometimes by accident we reinforce that when it is not necessary and when there aren't any good replacements for families, because therapists cannot be parents. We can see them. I see them all the times. We can develop a bit of an attachment relationships with them, but we are lousy attachment figures. We just do not have the present availability.

We are not available 24x7 that a real attachment figure needs to be. We want to help be the conduit of reattaching where attachment can happen, and that usually is the parents with most teens, unless there is something so severe going on that can happen, in which case then we have to move that somewhere else. I think that's really important. I mean I do this all the time now.

Somewhere along the line that clicked in for me and it happened and I remember with one case where all of the sudden I went, oh my god, what have we done. Now I'll tell you if we have enough time to tell this little story.

David: Oh yes. I want to make sure I understand what that 'it' is that you are referring to, becoming sort of over-identified as the super therapist, super parent or something.

Dr. Ocana: Yes, so what I am talking about here is where we have accidentally had the system alienated a young person from their family by our interventions, because it does happen actually way more often than we probably do realize. In the case I am thinking off, there was a young girl with anorexia. She ended up in the hospital with very bad anorexia and in the literature on anorexia, the old style literature, there was this idea that they had to separate the kids from their parents, that the parents were somehow the problem, and that if you separated them from their parents, the problem would get better.

Until very recently that would keep happening, and it is only been I think in the past maybe few decades or so, I don't know... Have you ever heard the Maudsley method for helping young people with anorexia, where they are engaged with the family and the family takes over the feeding? That is new. At least when I was training, that was fairly new.

Now at this point, it is a pretty accepted practice in helping young girls with anorexia, that we don't remove them from their families. We actually support the families in helping the young person recover from anorexia. We see the family as a resource to be drawn on rather than the problem. It is brilliant. It is absolutely brilliant and wow the outcomes are so much better.

David: There is an unfortunate history in psychotherapy and psychiatry of blaming somebody, blaming the mother, blaming the parents, etc., blaming the spouse, blaming the person who is not in the room.

Dr. Ocana: Exactly. With teens this becomes so easy to do because very often the teen is blaming their parents. Then we can easily collude with that, or we might say, the teen will tell us a few stories about their parents and we are like oh my god you know it is horrible, right, but we don't really get the context, the full context, and we need to build a relationship with parents.

Very often parents actually pick this up and they start to be not so happy about what is going on with their kids. We don't communicate often very well with their parents if we are not careful about this.

David: Yes, but as we begin to wind down here I know that you have some, I believe maybe, strong opinions, feeling about the current situation in psychiatry. Tell us about that.

Dr. Ocana: Okay. I think it is a mixed thing. In many ways there are lots of exciting opportunities that are coming up with neuroscience, and how they can inform our intervention, but we are also at a time of change. I mean, a number of your interviews have all talked about this. It is like a state of flux where I think there was a lot of optimism that certain approaches were going to bring really big advantages, like pharmacology and the DSM. In fact, that means a lot of positive things. We learned a lot of things, we learned doing many things, but we have also come to a stage where we haven't found the keys to the kingdom here.

The DSM categories don't map on to what we thought they might. They are actually quite muddy. They are actually not quite as crystal clear as we initially maybe thought that they were going to be as an entity. Our medications, they work sometimes and sometimes they actually don't, and sometimes they worked so much less than we thought they would. With some of the new information that has come out on the fact how antidepressants actually work, as compared to how we sorted the results from a mild to moderate depression, evidence is pretty weak but it is actually getting stronger that it doesn't do much compared to placebo.

David: Shocking to me to learn as a result of these interviews that I have been doing and that reading that I have been doing, that none of the psychotropic medications were developed from an understanding of the brain, but rather were some medication that was used for some other condition and it was accidentally discovered that it could help with this or that psychologically.

Dr. Ocana: There is a disillusionment. I think there is a little bit of disillusion that is happening right now. That is an interesting stage. I think it is a mixed bag. I think there are new opportunities, but we are in between stages. Wasn't it in one of your recent interviews they were talking about that stage in between where something is withering but nothing has yet taken its place entirely? That is the stage in which we are at. I think there is a lot of promise, but I think that we do have to do some rethinking about how we are understanding our diagnostic categories, how we are approaching and I think we have been very individualistic about the individual. I think that's a cultural thing that we glorify the individual and they somehow have this idea that everything resides inside the individual, but it is not that way and our neurobiology is very interpersonal. We can't really carve people off. I mean again, as a therapist we sometimes lose sight of that we need to help, we need to facilitate the interpersonal world of this young person or individual, not replace it. We have to keep that in mind at all times. Those are some different trends I think as to where I am seeing things go now.

David: Okay.

Dr. Ocana: Yes.

David: Well great. That is probably a good place for us to wrap it up. With that then, I will say, Dr. Michael Ocana I want to thank you for being my guest on ShrinkRap Radio and it has been good to get to know you a little better here.

Dr. Ocana: It has been a great pleasure for me David.