Straight Talk about Your Child's Mental Health

WHAT TO DO WHEN SOMETHING SEEMS WRONG

Dr. Stephen V. Faraone

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Dedicated with love to my parents,
who taught me the joy of learning
and the value of a good book.

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Contents

Acknowledgments

I owe much to the many teachers and colleagues who have helped me understand the causes, diagnosis, and treatment of mental illness. My graduate education at the University of Iowa and clinical training at Brown Medical School gave me tools, concepts, and facts which have been trustworthy guides for the past two decades. At Harvard, I have benefited from the stimulating environment created by Ming Tsuang, MD, PhD, and the faculty of the Harvard Institute of Psychiatric Epidemiology and Genetics. I also have had the great fortune to work with Joseph Biederman and the staff of the Massachusetts General Hospital's Pediatric Psychopharmacology Research Program, where I have learned much about the complexities of child mental illness.

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Introduction

Decades ago, nameless problems stopped kids from succeeding in school, making friends, and fulfilling their potential. Today these problems have names and treatments. Mental, emotional, and behavioral disorders are being diagnosed in children at a higher rate than ever before. Children who once got lost on their way to adulthood are now growing up to become competent and content adults.

Parents now have many resources to tap when they feel that something isn't quite right with the way their child thinks, feels, or acts. They can talk to teachers and pediatricians or search the Internet for the latest information. But the path to real help is neither straight nor smooth: Some kids are misdiagnosed. Some may be labeled and treated as abnormal when all that may be wrong is a tricky temperament or a difficult phase of life. Others are sent home with a dismissive wave and a "Don't worry so much" when there is in fact something to worry about. In still other cases, one problem is diagnosed and treated effectively, yet the child isn't "all better"—some other problem has been overlooked.

How are parents to make good judgments about what might be going on with their children? How do they find the kind of help they and their children really need while steering clear of unnecessary or even harmful assessments and interventions? How can they contribute to an accurate diagnosis and participate in sound treatment decisions? What do they need to know to protect their children from diagnostic errors and all the heartache that often follows? How can they be sure their child gets the best possible treatment? How can

they make sure professionals learn about their child's strengths so these can be used to help the child grow up healthy and happy in spite of any psychological obstacles that exist? And how can they get help from the health care and school systems that sometimes fail those most in need?

Decisions about what to do when something seems wrong are critical—not only to the well-being of children but also to their healthy development and successful transition to adulthood. Making correct decisions can spare parents a good deal of sleepless nights as well. I wrote this book to help parents find out what—if anything—is wrong, a crucial first step and more than half the battle toward solving any problems your child has. I also introduce parents to the types and sources of treatment used to help the psychological problems of childhood. My main aim is to help you get answers about what's wrong (and what's right) with your child. I'll give you up-to-date scientific information about the psychiatric disorders and minor problems that affect children today. You'll also learn about the ins and outs of the mental health care and school services now available to children and their parents.

So, if you have a child with a mental, emotional, or behavior problem, or think you might, read on. Learn how to detect problems before small problems become big problems and big problems become disasters. Take the old adage seriously: An ounce of prevention *is* worth a pound of cure. Act to prevent problems instead of reacting to problems that are out of control. Identify and deal with small problems before they grow into big problems. Identify and deal with big problems before they stop your child from having a happy childhood. If you combine this information with your intimate, indispensable knowledge about your child, the chapters that lie ahead should help you figure out your next steps in helping your child get the best help possible.

Parenting can be a hard job. I've learned this from scientific research and from my work as a clinical psychologist. But like you, I also know this from personal experience—I have three children. Raising kids is surely life's great adventure. Children, whom we love beyond words, lift us to peaks of joy and peace, but also drop us into the depths of worry and sorrow. Some days bring kisses and hugs and laughter and cheer. Others bring cries and whines and tantrums and

tears. As we ride this parental roller coaster we do our best to stay on track, to help our children become happy, well-adjusted adults.

Yes, guiding children from infancy to adulthood is a wild ride. But if you have a child with a psychological problem, that problem can begin to pervade the entire family. As the child grows, small problems grow to big problems if nothing is done to help the child. The joys shrink while the troubles expand. The entire family suffers. Parents fight over how to deal with the child, other children feel neglected, and the child with the problem worsens. When the normal aggravations of life explode into daily disasters, even the most skilled of parents needs help.

LEARN ABOUT THE FIVE PSYCHOLOGICAL PROBLEMS OF CHILDREN

To help you identify problems and how to deal with them, I'll describe the five main types of problems: disruptive behavior, moodiness, fear, learning disabilities, and abnormal development. Disruptive children disobey parents, teachers, and other authority figures. Sometimes they lie, steal, and get involved in other illegal activities. Always "on the go," they act before thinking. As a result, they often upset classroom and family activities and, as teens, are at risk for alcohol and drug abuse.

Moody children demonstrate extremes of sadness, silliness, or irritability. Some are down to the point of depression and suicide; others are up to the point of uncontrolled excitement and agitation. Often cranky, their whining and complaining create constant tension at home and sour friendships at school. Many are irritable almost all the time. Sometimes their irritability flares into explosions of physical violence.

Fearful children manifest extremes of nervousness and fright. Some extremely shy children may have been so fearful of their first weeks at school that tears and tantrums became a daily affair. Other fearful children constantly have the jitters or display fear of dogs, heights, strangers, or other objects or activities. These children are often well behaved. They keep to themselves and may not share their problems with parents or teachers.

Children with learning problems cannot learn reading, math, spelling, or some other subject as quickly or as completely as other children. They cannot correctly identify the letters of the alphabet, or understand simple arithmetic or spell simple words. Because they do poorly in school, peers tease and taunt them. Some parents, puzzled by their child's poor performance, grow frustrated and angry. After a long series of intense efforts that lead to failure, the child with a learning impairment forges a poor self-image. These kids may call themselves "stupid" as they withdraw into a private world dominated by sadness over their many failures to please parents and teachers.

Psychologists use the term *child development* to refer to the sequence of mental, emotional, social, and athletic skills through which children pass on their way to becoming well-adjusted adults. We say that development is abnormal when the usual sequence fails and the child lags far behind his or her agemates. As you will see in a later chapter, some children demonstrate pervasive abnormalities in development early in life. These children do not learn to communicate and have problems establishing normal relationships with parents and other children.

You may have already seen your child in the preceding brief descriptions. If not, you'll get a more detailed look at the different types of psychological problems in Chapter 1. Although it is convenient to divide problems into separate categories, you will also learn that many children have more than one problem. In fact, a child who has one type of problem stands a good chance of having others as well. Many popular parenting books make a crucial error: They try to pigeonhole children into one of several categories. You and you doctors need to see your child as an individual. That means learning about the child's unique pattern of psychological strengths and weaknesses.

LEARN ABOUT PSYCHIATRIC DISORDERS AND THEIR CAUSES

Some children have ordinary problems. Others have mental, emotional, or behavioral disorders (which I'll call *psychiatric disorders* most of the time for the sake of brevity). If you learn the difference, you and your child will be spared years of distress, impairment, and

aggravation. Because psychiatric disorders have been stigmatized by society, many parents refuse to think that their child may have one of these conditions. Such attitudes stop some children from getting effective treatments. Many children with mental, emotional, or behavioral problems will eventually see a mental health professional, but, due to pervasive societal attitudes about mental illness, these children are helped many years later than would have been ideal. This book will teach you the warning signs of mental illness (another term for psychiatric disorder) that signal the need for professional help.

Learn why some children have problems and others do not. Intensive study of problem behavior, especially in recent decades, has helped us understand why some children develop problems and how we can help them. For example, we know now that genes can make children more or less prone to behavior problems and psychiatric disorders. Does that mean that such children are "born bad," that parenting and the social environment cannot change problem behavior? You'll see that the answer is "no" and will learn how your child's genetic and biological handicaps combine with his or her social environment to create behavior problems and psychiatric disorders. If you learn only one fact about the source of these conditions, let it be this: In the large majority of cases, they are caused by a complex series of biological and social events. Genetic predisposition, family problems and crises, ingested toxins, inconsistent or misguided parenting practices, head injuries, pregnancy complications, difficult births, child abuse, unproductive peer relationships, drug abuse, and countless other factors can combine in complex ways to turn happy, thriving children into children who have problems and cause problems for those around them. As you will see, when we try to discover the reasons one child has a problem and another does not, we find no simple answer. Learn this lesson of complexity and you will stop blaming yourself, your spouse, your parents, your obstetrician, your neighbors, or your child's friends or teachers for your child's problems. Instead, use the lesson of complexity to make changes in as many factors as you can control, with the ultimate goal of helping your child live a normal and happy life.

Statements like "Beth is depressed because I have a terrible temper" or "Jake can't behave at school because he never gets any attention from his father" will always be inaccurate exaggerations of

parents' role in their child's problems. But a child's psychological problems can be a family affair: The way you and your children interact, the way siblings interact, and the general tone and pace of family life can worsen a child's problems or help solve them. Sometimes it takes courage to avoid the self-blame that is a common knee-jerk reaction to guilt and instead look a little more deeply into ourselves. But if you follow the philosopher's advice and "know thyself," you may find ways to help your child. Maybe realizing that your "high-strung" child is a lot like you will help you see your child's "problem" as more a matter of temperament than illness. Perhaps an unvarnished view of your own actions will show you how you're inadvertently modeling behavior that you find undesirable. Or maybe you'll gain confidence in yourself once you count up the many ways that you, your child's other parent, and your other kids are providing the love and support that your struggling child needs. With that confidence, you'll be able to set off on the road to helping your child get better.

LEARN HOW TO GET HELP FOR YOUR CHILD

You also need to learn about the kind of professional help your child needs. Perhaps his or her learning problems warrant special attention by the school. Or perhaps help from a mental health professional is needed. The psychological and medical sciences have discovered much about effective parenting. Use this information to eliminate problem behaviors, improve parent–child communication and make your child feel good about him- or herself. Learn how to reduce parenting stress so that you and your spouse can relax and enjoy your family.

Keep reading and you'll see that there are many types of mental health professionals and many types of therapies. It's confusing enough to choose among psychiatrists, psychologists, counselors, psychotherapists, art therapists, dance therapists, diet therapists, and so on. But what about all those therapies—behavior therapy, cognitive therapy, play therapy, medication, and more? Find out what therapy makes sense for your child and what type of therapist is most able to do the job.

As you read this book, please know that its goal is not to offer simple cures. Learn to be suspicious of magical cures and the gurus who sell them. These cure salespeople will charm you with simple solutions and intrigue you with dramatic stories about children who have been helped by their "new" therapy. These gurus provide engaging talk show entertainment, but their simplistic solutions will not solve the complex dilemmas posed by most children who have psychological problems. So don't join the therapy-of-the-week club. Fad therapies come and go, leaving troubled families in their wake. But scientific principles endure. Learn them and you will have the best possible shot at helping your child.

By science, I don't mean physics or chemistry, of course, but the science of human behavior: what psychologists and psychiatrists have discovered about childhood problems and how those problems can be solved. You don't need to drown yourself in scientific jargon to learn about this branch of science. What you do need is a healthy measure of critical thinking, a dose of skepticism, and an insistence on logic and data. I'll give you the data and the reasoning throughout this book; you'll apply the critical analysis.

I'm giving you a toolbox. Use its tools as directed and you will build a better life for you and your family. There are two sets of tools in this book. The first set will help you figure out the kind and severity of your child's problems. The second set will help you decide on the type of help your child needs. Thinking that you already know what type of problem your child has, you might be tempted to skip to the second section. Don't. Misunderstanding the nature of your child's problems is one of the biggest parenting mistakes you can make. Take some time to think about and understand your child's problems. Don't look for shortcut solutions. They do not exist.

And don't assume that a health care professional can do all the work for you. You have an army of professionals at your disposal: pediatricians, psychologists, psychiatrists, social workers, neurologists, neuropsychologists, and more. But you are the general of this army. You need to learn about your child so you can coordinate these forces and win the war against mental, emotional, and behavioral problems. To win that war you will need both strategy and tactics. Your strategy will be a detailed plan. It will tell you how to coordinate the main in-

fluences on your child's life. Your tactics will be the work you do each day to put your strategy into action.

So plan your work, then work your plan. In the end, you may not cure your child, but his or her problems will become less frequent and less serious and you will rest soundly knowing that you are doing your best to help.

Part I

UNDERSTANDING THE PSYCHOLOGICAL HEALTH OF CHILDREN

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Chapter 1

What Do Psychological Problems Look Like?

Because you're reading this book, I'll guess that you could make a list of what you see as your child's psychological problems. The list might be long, and you might have trouble making sense out of the many different items on it. Maybe they would include "shy, fearful, timid, and nervous" but also "belligerent, argumentative, moody, and disobedient." If you have such a list in your mind or on paper, consider it a first step in your journey toward understanding and helping your child. The goal of this first chapter is to help you begin to bring some order to what can be a bewildering pattern of problems. In the following pages I will group childhood psychological problems into five simplified categories that will give you a way to conceive of what you are perceiving in your child. I'll also help you hone your powers of observation by asking you many questions about where, when, how, and with whom your child exhibits the behavior, thoughts, or feelings that you're concerned about. Your list should end up much more detailed and specific, giving you a more complete picture not only of the problems that worry you right now but of all of your child's strengths and weaknesses.

You'll then use this information in Chapter 2, whose purpose is to give you a better idea of whether your child's problems are everyday challenges, possibly passing phases, or more serious issues that warrant a professional evaluation. From there, Chapter 3 will explain why your child may be feeling, thinking, or acting this way and how

the complexity of causes helps dictate the kinds of treatments that your child might need. In Part II you'll see how doctors translate the observations from your list about your child to specific diagnoses.

Getting a preliminary handle on your child's problems right now will probably reassure you—even if your list grows longer and longer as you continue to observe your child. Knowledge increases self-confidence, whereas amorphous worries fill us with fear and self-doubt. A long list may not mean a larger number of problems than you had thought but simply that you now have a better grasp of what is really occurring.

It's not unusual to magnify whatever seems "abnormal" in your child, because you want so much to protect your son or daughter. It's possible that nothing much is wrong after all; this book will help you find out. On the other hand, you may be so focused on a problem that aggravates you—say, your son's inability to sit still and keep quiet at the movies, in church, or when you're conversing with other adults or your daughter's constant need for reassurance that there is no monster under the bed, that the schoolbus won't crash, that you and her father won't get sick and have to go to the hospital—that you miss other problems your child is having. For example, when I asked Paul's parents why he needed help, they said he was disobedient and destructive both at home and in school. That was indeed a big problem. But, after careful questioning, I learned that Paul also had severe problems learning in school. His parents had known about his poor grades but had wrongly assumed they were due to misbehavior. After we assessed his learning problems and decided how to deal with them, teachers and parents were able to help him improve his grades; positive change in his behavior followed.

It's also easy to confuse one type of problem for another. Like Paul's parents, Amy's parents described her as disobedient and destructive. But her parents overlooked crucial facts: Amy was a shy and moody girl who thought poorly about herself and had few friends. Her misbehavior usually came on the heels of irritable moods or the approach of events that made her nervous. Amy had an emotional problem that caused undisciplined behavior. By dealing directly with her uncontrollable emotions, her parents were able to stop much of Amy's misbehavior.

These two stories illustrate the first principle of helping children

with psychological problems: to better gauge the psychological health of your child, gain a clear view of *all* your child's problems and how they relate to one another. This can be difficult to do, because children, like adults, are infinitely complex creatures. In addition, because they are children, they are not yet fully formed; every day brings new twists in the developmental roller coaster ride. So how do you know whether your child has an illness or is just going through a phase? Is your child suffering from a neurological abnormality or reacting to some pressure from the people and events in his or her daily life? Would the behavior that you consider odd be viewed that way by parents of other kids your child's age? How would a doctor view it? And how do you sort out the way your child acts, thinks, and feels in all the different domains in which the child is developing? How would you describe your child's level of emotional control? Does he or she anger easily, or calm down quickly after a disappointment? What kind of temperament does your child have? Shy when introduced to the new kid down the block? Or is he or she the child who organizes the neighborhood kickball game? What is his or her learning style? Does your child make up stories and act them out with her stuffed animals? Does he or she dismantle the clock to see how it works? How would you characterize your relationship with your child? Does he or she seem secure, greeting you eagerly when you come in the door and then returning to her board game, or does your child follow you around the house? How does your child behave within the dynamics of your unique family? Is he or she the peacemaker, running between you and your spouse when you're having a fight? Or does he or she insist on being the center of attention the minute a younger sibling starts to talk? Answering all these questions is a tall order, but it's critical to your ability to look at your child's behavior in the context of his or her personality, your family life, and the way your child learns, plays, and develops relationships. It will also give you information to determine whether your child may have a psychological problem that should be evaluated and to contribute to your ability to help a doctor figure out what's wrong and how to treat it if you do decide to seek help.

I'm sure I don't have to tell you that every child is unique. You can probably see that even within your own family. Some children don't seem able to control their behavior, while others are well man-

nered. Some have learning problems; others excel in school. Some easily make friends; others are loners. A simple list of the potential psychological problems of childhood would fill a book. Examples include stealing, lying, disobedience, not paying attention, school failure, sadness, nervousness, agitation, hyperactivity, strange rituals, fearfulness, shyness, panic, reading problems, drug use, fighting, and more. Any child can have any combination of these problems, among many others, in any pattern. Psychologists, psychiatrists, and other professionals have effective methods for assessing what kinds of problems your one-of-a-kind child has (if any). But they don't have the benefit of living with your child from day to day, as you do. Without your input, even the best professional evaluation will be fallible. That is why your first task is to compile as complete and objective a list as you can of how your child behaves, feels, and thinks.

The five categories of psychological problems explained in this chapter may seem oversimplified, and in a way they are. They are intended to help you extricate yourself from the tangle of objective observations, subjective judgments, and parental anxieties that we all bring with us when we try to do right by our children. They ask you to set aside any conclusions you've already reached, back up, and get down to the basics: How does your child act? As you begin this more scientific observation of your child, we'll nudge your acuity with lots of questions that will help you build the resulting two-dimensional picture back into the complicated three-dimensional human being your child is. You'll begin to perceive not only whether your child exhibits symptoms that fall under the category of unruly behavior, moodiness, fear, learning disabilities, or abnormal development, but also whether he or she has trouble with more than one category, how they may be related, and how they seem to affect and be affected by the various arenas in which your child operates, from home to school to the playground. You'll also find yourself noticing psychological strengths that your worry about problems may have obscured, and these will be important to catalog, too, especially if it comes time to take advantage of available therapies, where a child's strengths can often make the difference between continuing struggles and productive treatment.

The five groups discussed in the following pages may be oversimplified, but they are hardly arbitrary. They match up to the five

main areas children must master to become mature, well-adjusted adults. They must learn to control their behavior so that they can accomplish tasks and enjoy themselves without hurting or annoying others. They must learn about their emotions, the internal feelings that give depth and meaning to experiences. They must learn to be fearful and avoid danger but must not be so frightened or jittery that it interferes with their lives. They must learn from books to do well in school and, eventually, at work. To develop normally, they must learn to coordinate behavior, emotion, and learning throughout life so they can communicate with others and enjoy social relationships. When these domains of psychological life are individually nurtured and jointly coordinated, the child develops into a mature, well-adjusted adult.

These categories not only correspond to the major developmental tasks before a child but also represent groupings of problems that often occur together in a single child. That is, if a child has a problem from one of these groups, any other problems he or she has are more likely to be from this group than from another group. For example, a child who is frequently disobedient may exhibit another unruly behavior (such as stealing), because the overarching problem is the tendency to misbehave. While the child may have emotional problems or problems from one of the other categories as well, we usually see children who act out in one way act out in another. It would be less likely for an actively disobedient child to suddenly begin acting shy, for example. It's the observation that these various problems are often tied together in one child that has helped scientists solidify these groupings.

Although scientists have proved that psychological problems tend to cluster into one of these groups, they have also shown that these groups are not entirely separate from one another. It is true that many children seem to have one type of problem. They act out in disruptive ways, or their functioning is impaired by mood swings, or their lives are limited by excessive fears, or they can't progress academically along with their peers because of specific learning disabilities, or their development is delayed or halted. But some children face several of these challenges. As you might expect, children who seem to be struggling with several of the tasks they must master to become well-adjusted adults may be suffering more than others and

may need more help. Because knowing the full range of problems a child has is critical to devising successful treatment approaches, I urge you to look unflinchingly at how your child acts and what he or she seems to be feeling and thinking, in all of these categories.

DISRUPTIVE BEHAVIOR

Whether we call them disruptive, unruly, unmanageable, undisciplined, disobedient, out of control, headstrong, difficult, or just "a handful," disruptive children wreak havoc in the world around them. They may be disobedient, defiant, and intentionally disruptive. They may be loud, boisterous, and messy. They may be spacy and distractible, never listening to or following instructions. We've all seen children who fall into this category. From Dennis the Menace and the Little Rascals to Bart Simpson and the "South Park" kids, they provide a constant source of thrills and humor in American popular culture. But there's nothing funny about these kids when they live in your house. Unruly children seem to disrupt whatever setting they are in, making it difficult to complete daily routines or interact with anyone else when they are around. They often take the lion's share of a parent's attention, making it difficult for parents to attend to other children or enjoy their own lives.

Jerry's mother told me he was always an extremely active child, even as a baby crawling about the house. In preschool he could not sit still. His teachers had to chase him off tabletops and discipline him for throwing crayons. They described him as out of control and disruptive of the daily routine. At age 8, Jerry was considered the class clown, the one who never failed to draw an admiring guffaw from the other boys in the class or an exasperated sigh from the teacher. His homework was always late and usually illegible. His teacher said he was smart but rarely "on task." Even during the shortest test she usually found him staring out the window, tapping his foot or his pencil loudly, rather than finishing the quiz. Now 9, Jerry is starting to have trouble finding a group of kids that will let him join in whatever they're playing, because he almost always ruins the game with his antics. Even his oldest friends don't always invite him to their birthday parties, and instead of looking up to him his

classmates are starting to sneer at him and call him "Stupid." His teacher says he may have to repeat fourth grade.

Jerry exhausts his parents with his boundless energy and activity. He climbs on furniture, runs around the house, and cannot sit still watching television. Although his dad constantly tells him "Think before you act," Jerry seems to act mostly on impulse. He broke his arm one summer after jumping off the neighbor's roof on a friend's dare. Because he wakes early and cannot play quietly, his parents rarely sleep late; they never get a break from Jerry's antics.

Jerry's parents are at their wits' end. Their lovable "live wire" is now failing academically and socially, and he's developing a "mean streak" that is making him a lot less lovable to all but his immediate family.

Sam is 12. In preschool he too threw crayons and disrupted the class. By early childhood, however, Sam had graduated from throwing crayons to throwing temper tantrums, the typical ending to arguments with his parents. He often disobeyed them, protesting loudly that they were unfair. When they asked him to do chores, he became angry and ran out of the room. Most of the time his parents were too tired to chase him down. After all, they needed their remaining energy to deal with the arguments and tantrums they inevitably faced at bedtime.

In middle school Sam started provoking older peers with taunts and jeers, with no thoughts about the thrashing it would bring him. He often came home with torn clothes or a black eye. Now in junior high, Sam argues with teachers, calls out in class, fidgets in his seat, and fights with friends. The local police know him as an occasional shoplifter and frequent troublemaker. At lunchtime he bullies his way to the front of the cafeteria line. He shows talent in soccer but frustrates his coach by often leaving his position.

Sam's parents are thinking about sending him to military school—before he ends up in reform school. Because they know it's only a matter of time before he runs out of second chances with the local police, they spend sleepless nights agonizing about what kind of future he'll have. But sometimes they think military school is a desperate measure. Isn't it possible that Sam will just grow out of this rebellious phase, if they can only hang on a little longer?

Thirteen-year-old Gloria was neither defiant nor overactive dur-

ing the first dozen years of her life. She was messier than the average toddler and in preschool required constant teacher efforts to keep her focused on games or tasks. But overall she was a delightful little girl with many friends and content parents.

As she learned to talk, Gloria's father noticed that her mind always seemed to wander from one thought to another. She also flitted about from one activity to another, leaving a trail of unfinished chores, projects, and games. Her room became cluttered with toys, clothes, books, homework. In elementary school, Gloria's grades were average, but her teachers believed she could do better, especially if she would stop disrupting the class by speaking without being called on. Teachers described her as pleasant and sociable but were frustrated by her frequent daydreaming and gazing out the classroom window. She seemed more interested in the patterns of clouds seen through the schoolroom window or the periodic sounds of footsteps in the hallway. Gloria was also unpredictable.

Her parents began to worry about her when they noticed that she often acted without thinking. She would jump to conclusions about her friends, which sometimes led to bad feelings and broken friendships. Although she did not often break family or school rules, when she did it was very troubling, like the time she decided to stay out all night to watch a meteor shower. When Gloria began middle school, her parents became very concerned. Her grades dropped drastically and she began to skip school. Now, at 13, she's smoking cigarettes (she began impulsively on a dare from a friend) and she's spending most of her free time with new friends that her parents describe as misfits and troublemakers. Her parents worry that Gloria might be using drugs but do not know what to do. When they try to talk to her, she's evasive and generally unresponsive. She often doesn't come home when she's supposed to, and twice they caught her sneaking out of the house late at night. Gloria doesn't fight with her parents; she just doesn't pay any attention to them.

Although these three children are different in many ways, each disrupts people around them by disregarding household rules, school regulations, social conventions, or the laws of society. Some children are disruptive because they don't pay attention, are disorganized, or act without thinking. Others seem intentionally argumentative, dishonest, or even immoral. Their rule breaking may be only mildly an-

noying, like the child who refuses to wait his or her turn when playing games or daydreams instead of completing homework. Or it can be heartbreaking, as bewildered parents watch an apparently happy child become demoralized, maladjusted, and withdrawn. It can also be dangerous and destructive, as is the case with the child who steals, provokes fistfights, or uses drugs.

For the most part unruly behavior is easy to spot. But as Gloria's story illustrated, it doesn't always show up early in childhood, and, as Jerry's showed, it's not always hostile or belligerent. If you're not sure whether your own child exhibits problems in this category, examine the list of behaviors in Table 1.1.

As you think about the behaviors on the list, ask yourself several questions: Does my child act like this? If so, how frequently—once a month, once a week, or every day? Jerry's mother, answering this

TABLE 1.1. Examples of Disruptive Behavior

Disobeys parents or teachers	Has broken the law
Flits about from one activity to another	Lies
Does not finish tasks	Bullies younger children
Acts before thinking	Argues with adults
Is messy and disorganized	Loses his or her temper
Seems to have boundless energy	Is cruel to animals
Does not stay seated	Has physical fights
Has difficulty following instructions	Cheats in games
Does not play quietly	Has friends who get in trouble
Gets involved in dangerous activities	Has run away from home
Interrupts parents, teachers, or friends	Uses tobacco
Has difficulty waiting for his or her turn	Uses alcohol or drugs
Has temper tantrums	Refuses to do chores
Is distracted by sights, sounds, and activities	Cheats in school or when playing games
Disobeys teachers	Breaks household rules
Constantly annoys people	Damages or destroys property
Uses obscene language	Is unusually loud
Blames others for his mistakes	Skips out of school

question after Jerry's father had been away on a weeklong business trip, picked out 10 behaviors from the list and said Jerry exhibited them "every hour." Jerry's father, with the benefit of a recent break, reported more objectively that Jerry exhibited some of these once a week, others every day, and others only every month or two.

Does the behavior bother you or other people? It's a rare child who plays quietly all or even most of the time. But unmanageable children can seem so intrusive with their noise, the messes they make, and their rudeness or disregard for others that they are very irritating to parents, siblings, and friends. Sam's behaviors seemed designed to get to everyone around him. Gloria's behaviors were troublesome only to her parents and teachers—those who made demands on her and found them ignored. Everyone else she simply eluded. Similarly, most children have distractible times, but some children seem to lack the ability to focus to the point where they rarely pay attention in school or seem never to hear their parents' instructions. Is that how your child seems to you and others?

Does your child exhibit the behavior you're observing more than the "average" or typical child of the same age? It can be very difficult to judge a developing child in a vacuum. Without a point of comparison, we can't help relying too heavily on our own preferences and temperament in determining whether our child's behavior is "abnormal." Jerry's mother had been reared in a highly disciplined home. Until her husband reminded her that some of the behavior that she had labeled "outrageous" in her son could be seen in Jerry's cousins and neighbors, too, she was convinced that every display of exuberance from her son was another sign that he needed professional help. Consider other children you know or have seen. For example, you may have seen other children at your child's school, at sporting events, or while shopping. Follow the scientist's cue and amass as large a "sample" as you can. Because we know our own children so well, it's only natural for most parents to start by comparing their child with a sibling. Yet differences in temperament, frustration tolerance, and other factors can make it difficult to compare behaviors among siblings. Just because Gloria's older sister Janine is outgoing, on track, and a high achiever doesn't mean that something is wrong with Gloria because she does not meet the same standard.

Also recall conversations you've had with friends and teachers. A

teacher's point of view can be especially helpful because teachers, unlike most parents, regularly observe many children the same age as your child.

It's very important that you compare your child with children who are about the same age—no more than twelve months older or younger. Clearly, it makes no sense to compare children who are at completely different stages of development. As children age, they normally learn to follow rules and control their behavior. Compared with the average 10-year-old, most toddlers would be rated as messy and disorganized. That does not signal unruly behavior in the toddler. On the other hand, a toddler who insists she will go to school only if she can wear her pajamas is not showing the same behavior as the teen who skips school twice a week to hang out with high school dropouts at the mall.

As the examples of Gloria, Jerry, and Sam show, this broad category that we've been calling disruptive, unruly, or unmanageable behavior may show up in individual children in a wide variety of guises. Looking closely at your child and the list in Table 1.1 may begin to reveal particular patterns in your child. Maybe your child is overactive and impulsive but does not seem to be intentionally disobedient—just "wired" or "always on the go." It may turn out that the child who is "outright nasty" and destructive at home is merely sullen at school. Or the child who is "out there" or in his or her "own little world" can concentrate on some things better than on others. All of this information is valuable. It will contribute to your initial decision as to whether to have your child evaluated (see Chapter 2), and it will certainly be used in the diagnostic process if your child is evaluated.

Throughout this chapter you'll find tools to help you collect this information. The sidebars titled "Looking for Patterns" will help you zoom in on the details to better define your observations of your child. The sidebars called "Getting a Broader View" will help you step back and gain the benefit of a little distance from what you see as problems in your child. Here you'll look at the whole child (not just the problems) so you can better understand the contexts in which your child's problematic thoughts, feelings, and actions are occurring. Problems don't occur in a vacuum, and understanding your child's innate strengths and weaknesses will fill in the background in your picture of the child's current difficulties. These sidebars are in-

Looking for Patterns: *Where* Does This Happen?

When you're worried about your child's actions, thoughts, and feelings, the problem may seem to be running through the back of your mind all the time. It's easy in that case to mistake what's going on in your head for what's happening in life. You may think that your child behaves in the ways that concern you everywhere. But if you look carefully, you may see that's not the case. Think about these questions while you're observing the way your child acts.

1. Does your child behave this way in only one setting, in several, or everywhere?
2. In what specific places do you or others see this behavior?
   - At home?
   - At school?
   - In public places, such as restaurants, ballparks, movie theaters, houses of worship, and stores?
   - At friends' homes?
   - At relatives' homes? (At Grandma's house with the priceless Ming vase as well as at the cousins' house, where pandemonium reigns?)
   - Other?
3. Do these places have anything in common?
   - Are they places your child has never been before?
   - Are they places where your child feels very comfortable and safe?
   - Are the settings small and close?
   - Are the settings large and open?
   - Is the atmosphere free and unrestricted, as in a public park or playground?
   - Is the atmosphere restricted and governed by rules, as in a school, organized sports field or arena, or house of worship?
   - Are they places that your child is required to go to, such as school or house of worship?
   - Are they places that your child goes to at will, such as the playground or a neighbor's house?
   - Are they close to home?
   - Are they far from home?
   - Are they quiet, tranquil places?
   - Are they noisy, lively places?
   - Indoors?
   - Outdoors?
   - Can you think of anything else that characterizes the places where you see your child's problems most often?

If any patterns start to emerge as you explore these questions, take that information back to your laboratory—your child's life—and see if your conclusions are confirmed by future observations.

terspersed throughout the chapter, to be used in your ongoing observations of your child, along with the descriptions of all five categories of psychological problems.

If examining the list of unruly behaviors in Table 1.1 makes you think your child is unruly, don't make the mistake of skipping the rest of this chapter. Some children whose behavior seems out of control are also moody or fearful and some are learning impaired. They may also have some of the other problems described below. Keep reading to see if your child has these problems as well.

MOODINESS

Part of what makes us human is the wide range of emotions we experience throughout life. Without emotion, life would be a dull, drab,

Getting a Broader View: Your Child's Relationships

- In general, does your child get along well with others? With adults? With children?
- Does your child seem satisfied with his or her friendships? Are his or her regular companions the ones your child chose or would choose as friends? Does he or she complain about not having any friends or not having enough friends? Does your child worry about being popular?
- Can your child communicate well with teachers and other adults besides his or her parents?
- Is your child capable of the give-and-take that relationships require—at a level suitable for his or her age?
- Can your child assert his or her own needs and desires with others?
- Does your child ever seem lonely to you, without expressing it directly?
- Does your child confide differently in you than in your child's other parent?
- Do you and your child's other parent discipline your child in the same ways?
- How do your children get along? Is there a lot of fighting, or do they find ways to make up?
- Does your child seem happy to see you when you pick him or her up from school?
- Do you feel your child needs constant attention from you?

mechanical sequence of activities. But when we paint experience from the palette of emotion, our lives become energized with compassion, excitement, regret, happiness, grief, passion, and remorse.

Experiencing the full depth and range of emotion helps us live life to its full potential. But emotions can burst beyond normal limits. Extreme emotions can linger on and on and on. Such excessive, unrelenting emotions make it difficult for some children to carry out the normal activities of everyday life.

Susan was a quiet but happy toddler who had no problems playing with children, obeying her parents, or listening to teachers during her preschool years. She easily made the transition to elementary school, but her parents and teachers noticed her becoming more and more withdrawn from friends, teachers, and parents. Despite being a fine student with outstanding grades, small failures rattled her, teasing by schoolmates frazzled her, and any setback made her sad and irritable. Getting an A instead of an A+ on a spelling test could put her in a bad mood for a week.

Now, at 12 years of age, Susan still achieves outstanding grades, but she has lost interest in playing the clarinet, which once gave her many hours of pleasure. And despite her academic success and the many children she can count as friends, she is often sad, cries frequently, and believes that she is a total failure. Her sadness persists beyond occasional failures and often turns to irritability and anger. Her parents try to console and reassure her but are frustrated by their failure and angry about the tension that Susan's irritability has created among their other children. Susan is overwhelmed by irrational emotions, and her parents do not know how to help her.

For many years, Wendy was happy and well behaved. She was an above-average student, well liked by teachers and peers, and she had even stronger talents in soccer and baseball, where she led her teams to many victories.

By high school Wendy seemed poised for nothing but success. But after turning 15, she was troubled by bouts of extreme excitement and well-being that alternated with periods of profound sadness and irritability. These up-and-down moods muddled her formerly good judgment. Within a year, her grades worsened, she was caught shoplifting at the local convenience store, and she was ejected from a soccer game for cursing at the referee. In the now rare mo-

ments she spends with her family, she is angry and rebellious. She prefers to hang out with older teens, some of whom are known criminals and drug users.

Teachers and guidance counselors have told Wendy's parents that she is just another rebellious teenager going through a phase. "Just wait," they say. "She'll grow out of this as quickly as she grew into it." That conclusion may be premature. It looks as if Wendy might have a lot of things going on, and her parents, along with appropriate professionals, will have to find out whether she needs more monitoring or something more proactive, like professional help.

These children are very different from one another, but each shows the hallmark of moodiness: intense and persistent emotions that interfere with the activities of daily living. These intense emotions can cause minor upsets in the family, but they can also lead to life-threatening behavior, school failure, or social defeats.

There is one very important difference between disruptive or unruly and moody behavior. By definition, unruly behavior is easy to detect. The disruptive child breaks rules, which immediately annoys parents or teachers. Because rule breaking usually starts at an early age, parents with disruptive children usually realize they have a problem as soon as the child attends preschool or kindergarten. In these settings, the rules are explicit, and a child who has been in a freewheeling atmosphere may not adapt easily.

In contrast, some problems of mood are not recognized as such. Unlike behavior, emotions occur inside our skin. Although we can easily observe some expressions of emotion in children—sobbing, throwing things, pouting—we cannot directly observe the emotions themselves. This means the emotional meaning of any behavior is open to interpretation. Some mood states are obvious, but some others, especially as the child grows older, are harder to read and can easily be mistaken. Some children experience extremes of sadness without tears or other obvious signs that would alert parents. Children who get overexcited are often frequently and extremely irritable. Many adults view their irritability as normal teen turmoil or their misadventures as disruptive behavior. Because adults do not easily recognize moodiness in children, this type of problem is often ignored, which in the long run is not healthy for either the child or the family.

To help you detect moody behavior in your child, look at the examples in Table 1.2. As you think about the examples, ask yourself several questions: Does my child act like this or have these experiences? If so, how frequently? Does the behavior or experience interfere with the child's daily activities? Does it affect friendships, family relationships, or school performance? As you ask these questions, remember to compare your child to the "average" child of the same age.

At this point you have learned about two types of problems: unruly behavior and moodiness. If you find that your child shows many behaviors from both lists, you should try to figure out what connections might exist between the two types of problems. There are three possibilities to consider: (1) Moodiness causes unruly behavior; (2) unruly behavior causes moodiness; and (3) the two problems both occur, but one does not cause the other. It's useful to figure out if the

TABLE 1.2. Examples of Moodiness

Says that parents are not loving	Has low opinion of self
Has poor concentration	Feels guilty
Has sudden and severe changes in mood	Is indecisive
Has episodes of extremely unrealistic beliefs in own abilities	Is irritable or agitated
Has episodes of lots of energy	Has episodes of unusually happy or silly moods
Can go with little or no sleep for several days	Has episodes of low interest in usual activities
Feels sad	Has episodes of getting no pleasure from normally pleasurable activities
Has episodes of talking too much, too fast, or too quickly	Prefers to be alone
Gets involved in risky or self-destructive behavior	Has low energy level
Sometimes is very distractible	Thinks of death
Cries a lot	Is always bored
Feels hopeless or helpless	Shows self-destructive behavior
Talks about killing self	Does not eat well

two types of problems are connected, because that could give you clues about which problems to deal with first.

As an example of the first possibility, let's go back to Wendy. She was a pleasant and rule-abiding girl until she began to experience bouts of extreme excitement alternating with sadness and irritability. It was only *after* that point that she began to shoplift and rebel against her parents. This sequence of problems suggests that her bad moods might have caused her unruly behavior.

We saw the second possibility illustrated by 9-year-old Jerry. He was frequently irritable, crying, and throwing temper tantrums. But his extreme emotions always arose when he was trying to defy his parents. His crying and tantrums usually followed his parents' requests that he go to bed, do homework, or complete chores. If they let him do as he pleased, his emotional outbursts subsided. Jerry had learned that, at the right time, his bad moods would get him what he wanted.

It is also possible for children to have both problems without one causing the other. As you will see later, knowing what causes what will help you and a doctor figure out the best way to help your child. So, if you have an unruly, moody child, spend some time thinking about this issue. When you do, try to answer the following questions: Does moody behavior help your child get what he or she wants? Does it usually occur when he or she is defying you, teachers, or other authority figures? Are your child's emotions under control when he or she is between episodes of unruly behavior? Did your child's unruly behavior start before he or she began to have bouts of moodiness?

If you answered yes to all or most of these questions, you probably have a child who has learned that unruly behavior is a useful way to defy parents and achieve his or her goals. I said *probably* in the preceding sentence because the science of behavior provides few simple and certain answers. What it gives you is a method for finding the best possible help for your child.

By describing and classifying your child's problems, you are creating a small theory about these problems. As you read this book, your theory may grow to include other problems and how they relate to the ones you've already classified. Like any good scientist, you will test your theory by setting up a plan for helping your child. If your

Looking for Patterns: *When* Does This Happen?

Asked when their child's problems arise, most parents who are worried about their son or daughter will say, "All the time." That's rarely the case, however. What you can discern about exactly when your child acts, thinks, and feels in the ways that worry you can shed much light on the problem.

1. If the problem has been going on long enough to determine,
   - Does it occur year-round?
   - Just during the school year?
   - Just during summer?
   - During shorter school holidays?
2. When during the week do you see this problem?
   - Every day?
   - On school days only?
   - On weekends only?
   - Only on certain days of the week, such as Sunday (before the school week begins) or Friday (right before the weekend, at the end of a long school week)?
3. At what times of day does the behavior occur?
   - All day?
   - Only or mostly early in the day, after arising?
   - Only or mostly late in the day, right before bed?
   - Right after returning from school?
   - At other times?
4. Does the behavior seem to occur right before or after certain events?
   - Before it's time to leave for school?
   - Before it's time to sit down and do homework?
   - After being scolded or disciplined?
   - During or after family arguments or conflicts observed by the child?
   - During or after disputes with a sibling or friend?
   - Before, during, or after participating in competitive sports?
   - Before anticipated stressful events such as performances, tests, or doctors' appointments?
   - Before or after any other identifiable event?
5. Does the behavior seem limited to specific types of activities or events?
   - Holidays at which the extended family gathers?
   - Vacations?

- Mealtimes?
- Family outings?
- Visits to grandparents?
- Parties?
- Meetings?
- Other?

If you discover any patterns, observe your child with these patterns in mind. Are they confirmed? In what ways is your picture of your child's problems becoming clearer and more detailed?

plan fails, your theory or part of it was wrong. Don't lose hope. You will fix your theory to fit the facts and use that information to devise a better plan.

At this point, if you think you have a disruptive or moody child, you may be tempted to skip a few chapters to find out what you can do to help your child. That would be a mistake. You cannot help your child without seeing the "big picture." Only then can you come up with a clear idea about what is wrong and how to fix it. Does your child exhibit problems with fear?

FEAR AND ANXIETY

Fear can be an especially useful emotion. When we fear something, we avoid it, and that can protect us from harm. In fact, fear is so important to survival that our brains are specially wired to be instinctively afraid of certain life-threatening situations, such as being near the edge of a very high cliff, and to learn from experience to be afraid of others.

Fear is useful when a 5-year-old child becomes afraid as he starts climbing a 10-foot ladder, but it would be counterproductive if the same child became nervous or afraid every time he climbed the staircase at home. We want fear to keep children away from danger, not to interfere with normal, everyday activities.

Shan, a shy and quiet 8-year-old, avoids other children and is very nervous when he faces new situations. At age 3 he was so fearful of daycare that his mother had to stop work for several years. She ar-

Getting a Broader View: Your Child's Emotional Control

Emotional control is a major developmental task for children. Whether or not you believe your child has a problem with moodiness, how would you describe the child's overall emotional control?

- Does your child exercise emotional control that is appropriate to particular settings?
- Can your child control some emotions well (say, fear) but not others (e.g., anger)?
- Does your child seem to have control over the intensity of his or her emotions, or does the child need to be "talked down" when fear, anger, sadness, giddiness, or other emotions take hold?
- Is your child able to control the intensity of his or her emotions but unable to resist expressing whatever he or she feels?
- Does your child seem to hold in emotions for a certain period of time, only to explode or disintegrate later?
- What methods does your child seem to use to exercise emotional control—comforting self-talk, seeking parental or other support, physical release, relaxation, and so forth? Overall, does your child seem to be on a par with peers in emotional control?
- If you had to rate your child's emotional control on a scale of 1 to 10, with 1 as very weak and 10 as very strong, what rating would your child get?

ranged play groups for him, but he would cling to her when she tried to leave him with other children. When he was 5, his mother had to escort him to his kindergarten class and stay in the back of the room for the first month of the school year.

Today he is fearful of dogs to the point of screaming when he spies one from his bedroom window. Now and then he is overcome by a feeling of terror that leaves him gasping for breath with his heart racing. He often complains of stomachaches, especially when he must go somewhere without his parents or a trusted companion. Today he is able to go to school but has made no friends. This puzzles his teachers, who see him as a very pleasant little boy who always completes his work and never causes problems.

Most parents will easily see it if their child is shy or afraid of dogs. These fears are obvious because they lead to immediate behaviors in response to the feared object. But many children don't show

fear in such an obvious way. They might complain of physical symptoms such as stomachaches or trouble breathing. Or they may avoid situations without its being obvious to parents, who may misinterpret avoidance as defiance or lack of interest. Sometimes the child who refuses to go to bed on time is afraid of the dark, not disobedient. And the child who seems uninterested in playing with others may be shy rather than antisocial.

Other childhood fears are hard for parents to notice because they are very vague. For example, Jeff never acted fearful around anything specific, but from the age of 6 he was a jittery, jumpy worry-wart. Would he be late for school? Were his grades good enough? Did other children like him? Would he make the baseball team? For Jeff, every day was another day that something might go wrong. And it would probably be his fault. He never spoke about it, but that's how he felt.

Because Jeff's fears never stopped him from going to school or playing with friends, his parents just thought he was a bit quirky, but didn't think he had a problem. Although he didn't talk about his fears (many fearful children do not), Jeff was a very distressed child. His internal unhappiness would eventually surface in high school when his ability to communicate had matured enough so that he could share his thoughts and feelings with his parents.

Sometimes fears are so unusual that parents cannot see them for what they are. Throughout childhood, Shawna was a well-behaved, emotionally stable child who did well in school and had many friends. She had one quirk that bothered her parents. Shawna had an irrational need for her world to be neat, clean, and well organized, to the point of impossible hygienic perfection. By the time she was a teen, she dusted daily, polished her shoes to perfection, spent an hour cleaning the bathroom every other day, and used a handkerchief to open doors.

Her parents thought these and many other similar behaviors were odd, but they did not see them as a problem for many years. Warning bells would have sounded in their head if they had known what thoughts were driving Shawna's behavior. She was intensely afraid of being contaminated by a virus that would either cripple her, kill her, or destroy her mind. Whenever she thought about these lurking viruses, she would feel horrible inside, and the only way she

TABLE 1.3. Examples of Fearful Behavior and Feelings

Has episodes of racing, pounding, or skipping heartbeat	Has periodic chills or hot flashes
Has episodes of chest pain, pressure, or discomfort	Can't get his or her mind off persistent thoughts or images that are upsetting
Has episodes of difficulty catching his or her breath	Has repetitive behaviors or rituals
Has episodes of excessive sweating	Is afraid of dying, losing control, or going crazy
Complains of a choking sensation or lump in her throat	Clings to adults
Complains of light-headedness or dizziness	Is afraid of school
Complains of tingling or numbness in parts of his or her body	Is afraid of animals
Has episodes of shaking or trembling	Is afraid of people or situations
Describes feelings of unreality, or being detached from his or her body	Is highstrung or tense
Has unexplained physical complaints (e.g., stomach problems, headaches)	Bites fingernails
	Is jittery
	Is very shy

could get rid of the horrible feeling was to clean something. Eventually Shawna's parents realized something was wrong because she was spending so much time cleaning that she was neglecting her schoolwork and her friends.

As you can see, childhood fears come in many forms. To help you detect fearful behavior in your child, look at the examples in Table 1.3. As you think about the examples, ask yourself several questions: Does my child act like this or have these experiences? If so, how frequently? Does the behavior or experience interfere with my child's daily activities? Does it affect friendships, family relationships, or school performance? As you ask these questions, remember to compare your child to the "average" child of the same age.

Looking for Patterns: *With Whom* Does This Happen?

We all know that children often act differently with different people. Does your child's behavior depend on who is present? Ask yourself these questions.

1. Does your child's behavior depend on who is there?
   - Does the child act this way no matter who is present?
   - Does the child act this way only when alone (and observed unnoticed by the child)?
   - Does the child act this way only when others are there to observe?
   - Does the child act this way only in one-on-one situations or with groups?
2. With whom does your child act this way?
   - Mom?
   - Dad?
   - Both parents, but only when they are together?
   - Siblings?
   - All immediate family members?
   - Grandparents?
   - Other extended family members—aunts, uncles, cousins, and others?
   - Peers?
   - Older children?
   - Younger children?
   - Teachers?
   - Other authority figures—coaches, scout leaders, and the like?
   - Only with familiar people?
   - Only with strangers?
3. During what types of interactions does the child behave this way?
   - During arguments or other conflicts?
   - During relaxed and friendly encounters, such as when watching TV with family or hanging around with friends?
   - When being treated sternly or judgmentally, as when being scolded by a parent or supervised at school?
   - During formal conversations or exchanges, such as when meeting parents' friends?
   - During competitive interactions, such as games, sports, or contests?
   - Other?
4. Does your child act this way when being observed by certain people rather than interacting with them? By whom?

As you continue to observe your child, notice whether any patterns that have emerged are in fact borne out by the child's behavior.

LEARNING IMPAIRMENTS

In this fourth category we turn from behavior and emotion to thinking and learning. Like behavior and emotion, thinking and learning are essential parts of a child's daily life.

Children are learning all the time. In their preschool years they learn the basics of life: walking, talking, and eating. They also learn to relate to an ever-growing circle of relatives and friends. In preschool and then grammar school they learn reading, writing, and arithmetic. On the playground and around their neighborhood they learn how to make friends, get from one place to another, and behave among peers.

Psychologists have discovered that the human brain is prewired to learn many things essential to survival. The most obvious examples of this are talking and walking. Children learn to talk and walk without instruction. During the first 3 years of life they change from amorphous lumps of sometimes screaming baby fat to walking, talking curious toddlers.

We have all learned so much in our lives that we sometimes take for granted how essential learning is to success and survival. Imagine that you never learned to walk, to read, to write, to speak. Or what if you never learned to do arithmetic or socialize with friends? These gaps in learning would be devastating. That is the fate faced by millions of learning-impaired children each day.

Hector was a happy, active, talkative toddler. In preschool he easily made friends and impressed teachers. He created lovely art projects, showed much imagination, and greatly enjoyed story time. Preschool was a breeze. But when Hector entered grammar school, his best years were already behind him. First, his teacher noticed that he had problems recognizing letters and writing out the alphabet. Reading was a tremendous chore. While his friends raced through Dr. Seuss, Hector struggled with simple sentences.

Children can suffer from many types of learning impairment. Some have trouble reading, others cannot spell. Some cannot do arithmetic, others cannot write. We usually talk about learning impairments in specific school subjects because that is how they are first usually noticed. But describing an impairment this way is not enough. We must figure out why the child is having difficulties.

For example, there are many reasons why a child might find it difficult to read. Because most of us read with ease, we don't realize what a remarkable achievement it really is. For you to understand what I am writing now, you need to first see the ink on the page of this book. Then you must recognize that the ink forms letters, not numbers or meaningless scrawls. Having gone that far, you piece together letters to form those bundles of meaning we call words. Then you organize words into sentences, sentences into paragraphs, and so on.

Now, as your brain is putting all these pieces together, it's also using memory to recall what I wrote in the previous paragraph. Otherwise, if you could not recall the gist of that paragraph, what I'm writing now would make little sense. In fact, as you read this, your brain is recalling much of what I've already written and is also recalling facts from your personal life that explain why you are bothering to read this book.

As if piecing together text and recalling information were not enough, your brain is also making many, many small but important decisions. For example, it must decide how fast your eyes should scan this page. If I were to start using technical phrases such as "structural magnetic imaging studies of the cerebral cortex implicate specific regions in the etiology of dyslexia," your brain would likely slow down your eyes to give you more time to figure out what all that jargon means. Your brain must also decide where the boundaries are between letters, words, and sentences. If I use a word like *page*, as I did three sentences ago, your brain must decide from the context that I meant the page you are reading in this book. I was not referring to a page boy or to the message one sends when calling a pager.

As you can see, it is not enough to say that a child has a reading impairment. Perhaps the child simply has poor vision. That is easily corrected. But usually the problem involves those parts that make sense out of letters, words, sentences, and paragraphs. Some children cannot recognize letters. Others reverse letters when reading or writing. For example, they might see *b* instead of *d.* They might write *god* instead of *dog.* Some children can read letters, words, sentences, and paragraphs but cannot understand what they mean. Others understand what they mean but cannot remember what they have read for very long. Imagine if you had already forgotten everything that you

read in this book before this paragraph. That would make it very difficult for you to make sense out of this book.

The point of all this is simple: It is not enough to know that your child has problems with reading or with some other subject. You need to know what sensory or thinking impairments are at the root of the problem. You also need to consider your child's "learning style," which describes in broad terms the way his or her brain likes to receive and absorb information while learning. Learning researchers have shown there are several ways to describe a child's style of learning.

Is Your Child an Active or Reflective Learner?

Active learners learn best by doing something with the information being taught. The activity could be purely verbal, such as discussing the topic or explaining it to someone else, or it could involve building a physical model or making a poster that describes the information. Reflective learners prefer to simply sit and think about what is being taught. Unlike active learners, they are not bored by lectures or reading textbooks. That's the best way for them to learn. I'm not saying all children are either active or passive learners. Many are comfortable with both styles. But some primarily prefer one or another, which can lead to problems if the teaching method favors the style they do not use.

Is Your Child an Analytic or Intuitive Learner?

Analytic learners like learning the minute details of facts and procedures. By combining these, they will see and understand the "big picture." Intuitive learners prefer to learn the big picture first. Then they will see and understand the details. You see this dimension of learning most vividly in sports education. The analytic learner figures out how to swing a tennis racket or shoot a basketball by having the coach describe the details of the physical motion. The intuitive learner prefers to watch the coach and imitate his or her overall motion.

Analytic learners tend to be less creative than intuitive learners, who love surprise and innovation in learning. Unlike intuitive learn-

ers, analytic learners dislike tests, which measure how well they can infer new information from what has been taught. Analytic learners would rather be tested on the facts and procedure they have learned rather than having to apply them to a new problem.

Is Your Child a Verbal or Visual Learner?

Teaching makes much use of the written and spoken language. Textbooks and lectures form the backbone of curricula from grammar school through college. Verbal learners benefit greatly from the use of language as a teaching tool. They love to listen. They love to read. For them, simple words enliven and clarify the facts and concepts teachers want them to learn. Visual learners prefer to see a picture describing what they need to learn. That's why teachers cover classroom walls with posters, photographs, historical timelines, and diagrams. It's why teachers use flipcharts, films, and CD-ROM presentations to convey information. And it's the reason good textbooks include many illustrations and diagrams.

To help you detect learning impairments in your child, examine the examples in Table 1.4. You may know of these problems from your observations, your child's complaints, or conversations with teachers. As with the other problem areas, ask yourself several questions: Does my child experience these difficulties? If so, how frequently? Does my child always have the problem, or does it wax and wane with stressful events? As you ask these questions, remember to compare your child to the "average" child of the same age. Also, ask yourself whether any of these identified problems could be the result of the teaching methods in the classroom being at odds with your child's learning style. If so, you'll have to pursue this issue with the teacher. But don't think of your child's learning style only as a potential impediment if the child is having learning problems. Learning style can be tapped as a strength, too, in helping your child enhance academic success and also social acumen and other challenges of development.

After thinking about the examples in Table 1.4, you may have recognized some evidence of learning impairment in your child. If you have also seen evidence of disruptive, moody, or fearful behavior from the other tables, try to figure out if there is any link between

TABLE 1.4. Examples of Learning Problems

Makes letter, number, or word reversals	Is clumsy
Has a poor vocabulary	Had trouble learning about time
Confuses similar letter sounds	Makes careless errors on schoolwork
Not interested in storytelling	Cannot easily sound out words
Has trouble following a series of oral directions	Grips pencil in a tight, fist-like, or awkward manner
Has problems learning numbers, alphabet, days of week	Has trouble recalling what he or she has read
Has trouble recalling spelling words, math facts, history dates	Cannot easily copy drawings
Memory is poor for daily routines	Gets confused by math concepts
Struggles to understand concepts	Has trouble understanding what he or she has read
Does not persist at tasks	Has problems memorizing spelling words
Gets mixed up when arranging and spacing work on paper	Has problems forming sentences and paragraphs
Does not like to draw or trace	Does not participate verbally in class
Had difficulty learning left from right	Does not like to write
Cannot predict what will happen after hearing part of a story	Gets mixed up when following a sequence of steps
Is slow to recall simple facts	Cannot summarize information
Cannot come up with different ways to complete a task	Cannot do simple math
Does not plan very well	Cannot interpret body language or facial expressions
Acquires new skills slowly or not at all	Has trouble studying for tests

those behaviors and the learning impairments. For example, does your child get frustrated and act out every time he or she has challenging homework? Have academic difficulties developed at the same time as disruptive behavior at home, such as picking on a sibling or breaking household rules? Some learning problems are not easily attributed to other behaviors. If your child sees *god* instead of

dog, this is most likely not due to unruly or moody behavior. But if your child does not participate verbally in class, perhaps he or she is very shy. If he or she has trouble following oral directions, your child may be defiant. Likewise, some children whom teachers describe as defiant actually have learning impairments. These children are not stubborn; they simply cannot do the schoolwork that other children do with ease.

ABNORMALITIES OF DEVELOPMENT

Psychologists use the term *child development* to refer to the sequence of mental, emotional, social, and physical skills through which children pass on their way to becoming well-adjusted adults. Pervasive abnormalities of development occur when the usual sequence fails and the child lags far behind his or her agemates. By *abnormal*, we mean something has gone wrong with the normal process of development. By *pervasive*, we mean that the abnormalities occur in many areas of the child's life. To understand abnormal development, you first need to understand normal development.

Normal Development

Development is about the growth, improvement, and coordination of skills in all of the three domains we have discussed in this chapter: behavior, emotions, and learning. The key principle of normal child development is that it proceeds through predictable stages. To a psychologist, development becomes abnormal when the child either fails to reach an expected stage or reaches that stage at a much later age than the average child.

The first year of a child's life brings a good deal of developmental change. During the first month of life, newborns are helpless, spending most of their time sleeping and feeding. Psychologists have shown that they have basic sensory capacities: seeing, hearing, tasting, smelling, and feeling. But they are essentially passive; they respond to sensations but show few signs of interest in their environment. By 3 months of age, babies are much more ac-

Looking for Patterns: *How Long* Has This Been Going On?

When you're worried (and when you're frustrated and aggravated, too), it's easy to feel as if the problem has been with you forever and has always been as bad as it seems right now. With most children, neither is likely to be true. Step back and take another look:

1. How long has this problem been going on?
   - When did you first notice this problem? This may not be when the problem actually began. When you start to think that something is wrong, it's natural to look back and examine past behavior, too: Maybe you ignored something that was right before your eyes because you didn't want to face it, or maybe you downplayed certain behavior because you assumed it would go away. Or once you really noticed the problem, you decided that, really, your child has always been that way.
   - When did others notice it? Sometimes another view will be more objective because it's not colored by the love and protectiveness you feel toward your child. Has anyone else brought up the problem? A teacher, relative, close friend, or someone else who spends time regularly with your child but has a little more emotional distance than you do?
   - When did the problem begin to impair your child's functioning or contentment? When did you notice a change in the child's level of happiness, achievement (academically or otherwise), social life, or everyday routines?
2. Did the problem start suddenly or develop gradually?
3. Is it a constant in the child's life, or does it seem to come and go?
4. Has the problem built in intensity, severity, or frequency, or remained fairly constant?
5. Has the problem changed in nature or character or manifested itself in the same way as long as you've been observing it?

The evolution of a behavioral, emotional, or cognitive problem in a child is important to understanding the problem fully. This is an especially complicated issue considering that your child is always developing and changing, so pay particular attention to comparisons between the past, present, and near future.

tive. They explore their environment with their eyes, begin to make a wider variety of sounds, and show simple muscle movement by lifting their heads. They often return their parents' smiles, which shows that early development is not only sensory and muscular but also social—they seem to know there is something special about other humans.

By 6 months of age the senses have become more acute. The 6-month-old can localize sounds and is babbling. Although the babbling is nonsense, psychologists have shown that it is a necessary stage in the development of normal language. At this age babies are able to control head and arm movements. They show further interest in their world by grasping at objects and looking in the direction of sounds. They show an increased awareness of social differences around them. Instead of smiling at any human face, they reserve smiles for familiar people—parents, siblings, and others they see frequently. They show enjoyment in being cuddled.

By 9 months of age muscular development allows babies to control their trunk and hands. They can sit without being supported and begin crawling. They begin to show an interest in playing simple games like peekaboo. Their strong attachment to parents becomes clear, not only in smiling and cooing but also because they cry in protest when separated from them.

As children approach their first birthday, they show improved muscular control of their legs and feet and their hands and fingers. As a result they learn to stand and walk and to manipulate objects with their hands. During their past 6 months of life, babbling has gradually evolved into meaningful sounds to name favorite people or to request food. The development of language leads to more social interaction with parents, siblings, and other caregivers. We see the 1-year-old's growing sense of the social world in several other ways. One-year-olds react to simple verbal commands such as "No!" and to the sound of their own name. They show a wider range of social emotions, greeting parents with affection and happiness and backing away from strangers with fear or anger. They wave good-bye, play more simple games, and show an interest in exploring the people around them.

As this brief tour of the first year of life shows, child develop-

TABLE 1.5. An Overview of Child Development

Age	Perception/ thinking	Motion/muscle control	Language	Social activity
Newborn	Can hear, see, smell, taste, and feel; shows repetitive and reflexive behaviors	Minimal	None	None
3 months	Visual exploration	Lifts head	Grunts and coos	Smiles
6 months	Looks toward sounds	Head and arm control, grasping	Babbling	Recognizes parents, enjoys cuddling
9 months	Associates sensory stimuli; searches for hidden objects	Sits up, crawls	Babbling begins to sound more like language	Plays games; cries on separation
1 year	Begins to understand cause and effect	Stands, walks, and manipulates objects	Simple words	Wider display of emotion to social stimuli
1 year 6 months	Curious about reflection; imitates others	Walks longer, crawls up stairs, uses crayons	Repeats words	Obeys commands
2 years	Identifies simple pictures, likes to look at books	Runs, kicks balls	Knows about 200–300 words	Throws temper tantrums; plays alone
3 years	Can think about something without it being present	Rides tricycle, shows improved drawing skills; cuts with scissors	Uses short sentences; knows 800–900 words; tells stories	Enjoys being with others; understands facial expressions of emotions; has sense of humor
4 years	Begins to understand logical concepts	Stands on one leg; draws circles and recognizable objects	Uses longer sentences; knows 1,500–1,600 words	Plays group games with children; imitates parents
5 years	Can read name, name colors, understands truth and lying	Can skip, jump, draw squares and triangles; dresses self	Knows about 2,000 words; has mastered simple grammar	Competitive with others; prefers sex-appropriate play; has special friends; shows responsibility

ment proceeds rapidly in many domains to transform the helpless, passive infant into a curious, mobile and socially active 1-year-old. Table 1.5 shows you an overview of development throughout the first 5 years of life. I've limited it to 5 years to give you a general idea of how development proceeds. Also, the disorders of development you will learn about in this book are recognizable by age 5.

Table 1.5 is not intended to allow you to diagnose your child's development but to give you a general idea of how the many complex skills of an adult emerge from the limited set of simple abilities we have at birth. Five general principles guide the normal development of children.

Child Development Principle 1: Child development unfolds in a predictable sequence. Simple skills emerge first. Then, as the brain matures and the child learns, these simple skills are arranged into more complex sequences. Consider the development of language. The normal developmental sequence of skills is babbling, meaningful sounds, simple words, complex words, short sentences, longer sentences, conversation, stories.

Child Development Principle 2: All normal children march through the same sequence, but some move through the sequence faster than others. This is another reason to view Table 1.5 as only a very rough guide to development. There is a close link between age and development, but it is not perfect. For example, on average, children will be using simple words by age 1. But some children use words earlier (or later) than average. So not developing as fast as the table suggests is not necessarily a problem. Many children develop slowly but eventually catch up to their peers.

When development goes awry, however, children get stuck at a developmental stage. They either do not progress to further stages or progress very slowly. For example, a 4-year-old who speaks with the language skills of a 2-year-old is showing signs of serious developmental delay. Development is like a foot race. It's okay to be lagging by a short distance, which can be erased by a sudden burst of speed. But the farther you lag behind the leader, the less likely you can stay in the running. When a child shows serious developmental lags, he or she falls behind in lots of areas: If you can't read, you can't do social studies; if you can't do addition, you'll struggle with subtraction.

Child Development Principle 3: Your child's biological makeup places limits on his or her development. I have a friend who, in high school, was a great basketball player. He had dreams of the NBA, but because he never grew taller than 5 feet 3 inches, he could not achieve that goal. His physical development limited his ability to compete at the college and professional level. Put simply, biological development constrains achievement.

This principle applies equally to mental and social skills. Consider reading. If the area of the brain that serves reading does not develop correctly, the child may develop dyslexia and never read normally. The same is true of the complex social skills children need to get along with parents and friends. Most children learn to smile when another child smiles at them. They learn the implicit social rules needed to play with other children. Learning these skills requires correct brain development. If this fails, the child may never adequately develop these skills.

Child Development Principle 4: Although biology constrains children in many ways, biology is not destiny. The process of development is not simply a reflection of brain development but requires your child to interact with adults and peers in addition to facing the physical and mental challenges posed by the environment. For example, our brain has been prewired by evolution to learn language easily. But to learn a language, your child needs to hear it and practice it. The same is true for other intellectual, physical, and social skills.

To understand why biology is not destiny you have to comprehend the concept of developmental probability. For any given child, some developmental outcomes are more likely to occur than others. A developmental probability is the probability that a specific outcome will occur given the developmental history and trajectory of the child. Because of his height, my friend the basketball player had a very low probability of ever being recruited by the NBA. He might have improved that probability if he had had a better coach, had practiced more, had had more encouragement from parents, or had a strong dose of the extreme motivation that allows some humans to overcome incredible obstacles. Biology is not destiny, but it does make some outcomes more probable than others.

Child Development Principle 5: Children actively participate in their own development. You and your child also play a role in making some developmental destinies more probable than others. For development to proceed smoothly, the child must be exposed to appropriate developmental challenges. If the challenges are too difficult, he or she will fail, limiting developmental progress. If they are too easy, he or she will succeed but may lag in development if not presented with harder tasks.

Parents help move development along by exposing the child to challenges suitable to his or her developmental level. Another friend of mine, Jake, did become a basketball star, thanks in part to being 6-foot-8 as an adult. But it might never have happened if his dad hadn't put a small hoop and ball in Jake's crib when he was 6 months old. Jake would not be shooting baskets at that age, of course; his challenge would be to grab at the ball, feel its texture, and learn how it reacted to touch. At age 1 Jake was throwing the ball out of the crib and watching his mom or dad return it. He watched with curiosity as Dad dropped the ball through the hoop and eventually tried it himself, but more often he grabbed at it with both hands and ripped it down. In doing so, he was learning simple motor skills such as the effects of grasping and pulling.

As Jake got older, he learned much about balls: how they bounce, how far they rolled when pushed, how much damage they did to Mom and Dad's home furnishings, how far they could be thrown and kicked, how they hurt when he was hit on the head, how he could throw them with accuracy and speed. These simple motor skills had little resemblance to NBA basketball, yet they were beginning a sequence of motor and athletic development that eventually allowed Jake to heave a basketball so that it arches over his opponent and swishes through the nylon mesh of a basketball hoop. None of this would have been possible if Jake, as a baby, hadn't explored the potential of playthings placed in his crib by his parents.

Through development, children actively construct knowledge by interacting with their world. They are not empty vessels waiting to be filled with information by parents and teachers. Thus, for your child's development to proceed smoothly, it is essential that you give him or her the chance to construct knowledge through exploration and interaction with the environment.

Getting a Broader View: Your Child's Temperament

"Is something wrong—or is it just Jason's temperament?" This question is right at the top of the list for parents who are perplexed by their child's behavior. What kind of temperament would you say your child has?

- Would you describe your child as relaxed, easygoing, laid-back, mellow, lazy, roll-with-the-punches, resilient, uncompetitive, adaptable, flexible, happy-go-lucky, carefree, nonchalant?
- Would you describe your child as high-strung, intense, wired, picky, prickly, ornery, volatile, quick-tempered, sensitive, peevish, fussy, meticulous?
- Is your child a loner, a joiner, or a leader?
- Is your child happiest with one friend at a time or in a large group?
- Is your child outgoing or shy?
- Is your child empathetic and compassionate compared to other kids his or her age?
- Is your child physically demonstrative or reserved?
- Would you describe your child as quiet or noisy?
- Would you describe your child as calm or energized?
- Is your child a talker, a thinker, or a doer?
- Is your child cautious or adventurous?

Pervasive Abnormal Development

Sylvia and Peter sensed there was something wrong with their second son, Roger, when, as an infant, he was not soothed by maternal caresses and cuddling. In fact, he seemed to resist Sylvia's affections. As a toddler, Roger began to walk and speak, but these skills developed slowly, with much difficulty. Roger was also emotionally distant. He avoided eye contact, did not respond to his parents' smiling, and preferred to be alone. Eventually he stopped speaking on his own and would only parrot back what he heard from his family members. Avoidant of others, he would sit in his room rocking himself for hours on end, seemingly unaware of the presence or absence of others.

Roger never learned to play with his brother or other children and never learned to read. Every now and then he would hit, kick, or bite other children for no apparent reason. At the age of 4 he would become upset to the point of screaming when changes were made to

TABLE 1.6. Examples of Pervasive Abnormal Development

Avoids people	Is emotionally remote
Shows delayed language development	Engages in repetitive behaviors
Does not like being touched	Is painfully sensitive to some sounds, tastes, textures, and sights
Has poor eye contact	Does not smile
Prefers to be alone	Does not seek comfort from parents
Is not upset when parents leave and not happy upon their return	Cannot understand facial expressions such as smiles and grimaces
Cannot take the perspective of others	Is physically aggressive to property and people
Likes to stimulate self through rocking, head banging, or other unusual activities	Develops strange, repetitive habits such as turning on all the house lights every morning
Gets upset when environment or routine changes.	Does not engage in imaginative play
Not bothered by extremes of temperature or pain	Obsessed with order (e.g., lines up toys in closet, leaves comb in a specific position on table)
Plays for hours with a single toy	Does not play with other children

the family home. One day his mother rearranged the furniture in the living room. When Roger saw that, he began to cry, scream, and claw at the couch. He became equally upset if changes were made to his almost ritualistic daily routine. For example, every morning he insisted on first turning on all the house lights, then having a bowl of Cheerios, and then getting dressed.

As you can see, Roger's problems affected nearly every aspect of his life. Table 1.6 lists many signs of pervasive abnormal development, most of which are evident by age 5. As you think about the examples, ask yourself several questions: Does my child act like this or have these experiences? If so, how frequently? Does the behavior or experience interfere with my child's daily activities? Does it affect friendships, family relationships, or school performance? As you ask these questions, remember to compare your child to the "average" child of the same age.

LEARNING MORE ABOUT YOUR CHILD'S PROBLEMS: THE NEXT STEP

If you have read this far, you've learned much about the five main types of child problems: disruptive behavior, fear, moodiness, learning disabilities, and abnormal development. You've also had time to think about examples of these problems and how they apply to your child. Now that you have a better understanding of the nature of your child's problems, you may be tempted to jump ahead to the chapters that show you how to help your child. Don't. Please take time to read the next two chapters first.

Chapter 2 will help you get a better idea of whether your child's problems are part of a passing phase or something more enduring, whether they are mild and thus manageable or more severe, and how great an impact they are having on the health and happiness of both the child and the whole family. You'll use your answers to the questions posed in this chapter—about how frequently your child exhibits the problems you've observed and how intensely and broadly these problems affect his or her life—to begin to get an idea of what you should do about those problems.

Chapter 3 then describes, in simple terms, why some children have problems and others do not. As a scientist, I have learned that I'm better at solving problems if I understand why they have happened. In my clinical work, I've also seen that parents do a better job helping their children if they know not only the nature of their child's problem but also the possible reasons the problem exists. With this understanding as a foundation, you should know whether you want to seek an evaluation of your child and get treatment for his or her problems—the subject of the chapters in Part II.

Chapter 2

Health versus Illness

When Do Everyday Problems Become Disorders?

Chapter 1 should have given you a better idea of where your child's problems lie. But you still may not know how serious they are or what to do about them. Can you wait and see if the problem is just a phase? Should you have an informal conversation with the school social worker sometime in the next few weeks? Should you make an appointment with your child's pediatrician right now? Should you call everyone you know and get the name of the best psychologist or psychiatrist in town? This chapter will help you gather objective evidence about the severity of your child's problems and how much your child is being harmed so that you can answer such questions confidently.

Note, however, that if you're losing sleep because you're so worried, or you're losing your temper because you're so frustrated by your child's behavior, or you're losing your sense of family tranquillity and cohesion because of your child's disruptiveness, it may not matter exactly how severe your child's problems are according to objective measures. What matters is that you have a problem that is becoming intolerable. You need to seek help. You may find that the problem is not your child but something else entirely, in which case an astute doctor will either steer you to whatever help you need to

resolve your problem or offer the reassurance from an expert that will restore your peace of mind.

It's important for the mental health field to establish firm criteria for diagnosing each disorder so that all children who need help get it and so the same standard of care is upheld throughout the country. But these criteria are not meant to deny help to children who are suffering yet don't quite meet the definition of a disorder. As you continue your quest to determine whether your child's problem is severe enough to require professional help, try not to get too caught up in dichotomies like "normal versus abnormal," "well versus ill," and "everyday problem versus disorder." Always, your goal is to determine whether your child needs the kind of help that mental health care can provide.

MEASURING YOUR CHILD'S PROBLEMS: A PRELIMINARY ASSESSMENT BY PARENTS

There are two ways to determine whether you should seek professional help for your child's psychological problems: by measuring roughly but objectively how big the problems are or by measuring your own reaction to them. I've already said that if you're finding the problem intolerable, you should seek help. But if you're unsure whether there is really something wrong with your child and are leaning toward a wait-and-see approach, your decision might best be made by estimating how severe the problem is. Psychological problems, like any other problem, fall along a continuum, from those that deviate only slightly from "normal" or "average" for children of the same age to those that are extremely different from the norm. Children who can benefit from professional intervention don't fall on one single point along the continuum but occupy a fairly sizable segment of it.

For each category of problems described in Chapter 1, I urged you to ask yourself these questions:

- Does your child act like this or have these experiences?
- If so, how frequently?
- Does the behavior or experience interfere with your child's

daily activities? Does it affect friendships, family relationships, or school performance?
- How does your child compare in this way to the "average" child of the same age?

Let's look at each of these measures individually. In total, they should give you an idea of where your child falls along the continuum.

Signs and Symptoms: Does Your Child Fit the Description?

To help you understand how health professionals separate normal from disordered behavior, I'll use the example of 7-year-old Raymond, whose parents came to see me because they thought he might have attention-deficit/hyperactivity disorder (ADHD). Ray's mother had learned about ADHD from a parenting magazine, which taught her that ADHD children were easily distracted, acted without thinking, and were often hyperactive.

As you'll see in Part II of this book, every psychological disorder shows up in children as a unique pattern of thoughts, feelings, and behaviors. Doctors call these signs and symptoms. A sign is something that can be observed directly, such as crying over a lost toy. For example, Ray's mother told me that Ray was always moving around. He could not sit still for long and was always moving about the house. Teachers complained that he fidgeted in his chair and would blurt out answers without being called on. These are all signs of ADHD. A symptom is something that the child tells us about but we cannot observe. Feeling worthless is a symptom of depression. We can't observe the feeling, but the child can tell us about it. When I asked Ray why he had problems doing homework, he told me that the sounds of his brothers playing in the next room made him forget about his homework. Ray's distractibility is a symptom of ADHD.

This definition of the distinction between a sign and a symptom may not coincide with the way you would use the terms, but it is technically correct in the fields of psychology and psychiatry. Because any doctor you take your child to may use the words this way, it's a good idea to be aware of this usage. Throughout this book, however, I'll use the word *symptoms* more broadly, to mean both signs

and symptoms, unless the distinction is important to the point being made.

Look back at the tables in Chapter 1 that seemed to describe your child. Does your child act in these ways or have these experiences? How many? Can you think of other, similar signs and symptoms that might fall into the same category or categories?

After speaking with Ray's mother, I discovered that she was concerned about many of these signs and symptoms. Ray did not finish tasks, could not play quietly, argued frequently with his parents, was messy and disorganized and flitted from one activity to another. He also had a bad temper and was a bully at school, where he had been disciplined for breaking school rules.

Frequency and Duration: How Often Has Your Child Exhibited This Problem?

After my first conversation with his mother, I had a very general idea of Ray's problems, which all fell into the area of disruptive behavior. But before I could recommend treatment, I needed to be sure that Ray was not simply acting his age. I had to be sure he had a disorder.

A disorder is more than just a cluster of signs and symptoms. A doctor would not describe a child as disordered unless the signs and symptoms were extreme, more frequent, or more intense than expected for the child's age. A 4-year-old child who cries once a month would not set off the alarm bells of concern. That would not be unusual. But crying for hours every day is unusual. That would be seen as a sign of disorder. As you might expect, the more frequently a problem occurs, the more likely it is that it signals a disorder that requires a doctor's attention.

For the signs and symptoms that you listed for your child, how frequently do they occur? Several times a day? Once a day? Once every few days? Once every couple of weeks? Less frequently?

When I asked her questions about frequency and duration, Ray's mother told me that Ray had been "on the go" nearly every day since he was 4 or 5. His disorganization, distractibility, and acting without thinking were equally frequent. In contrast, although she was very concerned about bad behavior at school, Ray had only played the bully once and had been disciplined for rule breaking no more than a

few times each year. The frequency of Ray's hyperactivity, inattention, and impulsivity concerned me; the frequency of misbehavior at school did not.

Severity: How Extreme Is the Problem?

In addition to a problem's frequency, doctors check into its intensity. Is it mild, moderate, or severe? There's a big difference between 2 minutes of whining that lead to a few tears, which is normal for a 4-year-old, and an hour of sobbing that leaves your child exhausted in a puddle of tears. There's a clear difference between the teen who disobeys his parents by coming home 10 minutes past curfew and the teen who steals from the local grocery. A doctor uses the frequency and intensity of signs and symptoms to separate what is normal from what is not.

As you may have guessed, I asked Ray's mother many questions to learn about the severity of Ray's problems. Doctors usually do this by asking for examples of what the problem behavior is usually like and what it is like at its worst. For example, Ray's distractibility during homework usually meant that some of the work was unfinished or he ended up in an argument with his parents. At its worst, none of the work was completed, he had a shouting match with his father, and he went to bed in tears. Ray's impulsivity was usually seen in his interruptions and intrusions, which irritated friends and exasperated teachers. When it was at its worst, the friend would stop playing with him or the two might argue. The teacher would reprimand him and make him do extra homework. An important way to judge the severity of a child's problems, which is reflected in the wording of the diagnostic criteria for the disorder, is to determine how much distress and disability it causes.

Distress and Disability: Does the Problem Affect Your Child's Daily Life, Relationships, and Academic Performance?

As you've seen, Ray had some signs and symptoms, many of which were frequent, enduring, and severe. These problems concerned me, but before I could make a diagnosis, I needed to be sure that they were also causing him either distress or disability. Distress or disability is the one

feature all psychological disorders have in common. When deciding whether you should seek an evaluation of your child, the distress and disability the problem causes his or her may be the most important factor to consider. Put simply, if your child is upset and not functioning the way he or she has and can, the child deserves help.

Every day a child remains distressed or disabled is one more day of life he or she is not learning to his or her fullest, not participating in family life to the fullest, and not building friendships. Childhood is a time when children usually make great strides in many areas: language, socialization, emotional development, nonverbal communication, moral development, relationships with authority figures, and so on. They don't need the challenge of a psychiatric disorder to hold them back.

A child is distressed if his or her signs and symptoms lead to emotional suffering or physical harm. Sometimes distress is obvious. The impulsive child who climbs a tall tree and then falls and gets hurt is clearly hurting. So is the child who is so sad that he or she cries all day and tells his or her parents that life is not worth living. But some distress is hidden to the world. It remains inside the child's mind. For example, Ray was very unhappy with his friendships. He felt that other kids did not like him, but he did not know why. He was also worried about his poor grades—so worried that he would sometimes stay awake at night. To learn about such hidden distress, you need to take the time to ask questions about potential areas of distress while listening carefully to the answers.

You should be especially attuned to any distress that might follow on the heels of a perceived psychological disability. A child is disabled if the signs and symptoms stop him or her from achieving the ordinary goals of childhood. For example, Ray was having a difficult time making and maintaining friendships. I considered that to be a social disability. He was also doing poorly in school, more poorly than he should have been, given his overall level of intelligence. That was an academic disability. Some disabled children have been left back in school, and others cannot make friends or cannot avoid fighting with siblings and parents.

After learning more about Ray, it seemed clear to me that he had ADHD. His signs and symptoms of that disorder were frequent, enduring, and severe. They also caused a good deal of distress and dis-

ability. In contrast, I didn't think his misbehavior at school warranted any other diagnosis of disruptive behavior. The signs and symptoms of these other disorders were no worse than I would expect given his age.

Armed with Ray's diagnosis, his parents got him the help he needed. His pediatrician prescribed one of the medicines that treat ADHD. I helped his parents learn how to manage his behavior at home and showed his teacher some methods that would help him learn better at school. Today Ray is doing very well. He still needs medicine to control his ADHD symptoms. Fortunately, the treatments worked very well. The problems that brought him to my office are not completely gone. But they are less severe and less frequent. They no longer interfere with his everyday life.

"Normal" Is a Moving Target, and So Is "Average"

You may see some similarities between Ray and your child, or there may be no resemblance at all. Every child is unique, and a million combinations of signs and symptoms, frequency, and severity are possible. That is one reason why many parents become frustrated and bewildered when trying to figure out what seems wrong with their child.

One difficult question for parents is how to figure out if their child's signs and symptoms are unusual for his or her age. We expect 2-year-olds to be more hyperactive than 8-year-olds. But how much hyperactivity is too much at each age? I can't possibly give you examples for every sign and symptom at each age, but Table 2.1 provides examples of normal and abnormal symptoms for a 6-year-old child. It will give you an idea of how to think about your child's problems.

Now review all of your rough estimates of the frequency, duration, and severity of your child's problems, the amount of distress and disability they are causing, and how your child compares in these ways to the average child of the same age. If you had to place your child on the continuum for the problems you've observed, what spot would you choose? If you've observed signs and symptoms of more than one of the five categories of childhood problems laid out in Chapter 1, use one continuum for each category.

This exercise may confirm your fears: There may very well be

TABLE 2.1. What Is Normal and Abnormal for a 6-Year-Old?

	Frequency	Duration	Severity	Distress and disability
Normal distractibility	Every few days	6 months	Sometimes interferes with homework.	No change in grades. No family conflict.
Abnormal distractibility	Daily	1 year	Usually interferes with homework.	Decline in grades. Fighting with parents about homework.
Normal irritability	Every few days	1 month	Argues with parents sometimes.	No change in grades. No family conflict.
Abnormal irritability	Daily	1 year	Argues with parents and teachers. Gets into physical fights at school.	School grades declining. Has poor relationships with other children.
Normal shyness	At parties and with strangers	1 month	Has refused to go to some parties.	No problems with friends. Normally social at school.
Abnormal shyness	Daily with peers at school and around familiar people	1 year	Never attends parties. Is withdrawn at family gatherings.	Has few friends. Feels like an outsider and unhappy around others.

something wrong, and you should consider seeking professional help. Or it may tell you that your feeling about your child's behavior was exaggerated. In this case, you'll have to decide how distressed and/or disabled your child, your family, and you are because of these problems. Sometimes parents find that just realizing the problem may not be as serious as they had feared reduces their distress considerably, in which case they might decide to wait and see how things go if their child is not particularly distressed either. Other insights that you might gain from this exercise include noticing that the problem that

bothers you most or disrupts your family's routines most may not be the one that is most severe or disabling to your child. Or you may simply discover that your child seems to have problems in three categories rather than the one that popped out at you before. Store this information away for use when you talk to a mental health professional during your child's evaluation (see Chapter 10).

If you're still uncertain and brimming with questions, that alone is good reason to seek professional help. Doctors are trained to separate normal problems from psychological disorders. You are not. Like many parents, you'd like to handle your child's problems on your own. But sometimes normal parenting is not enough. When should you seek professional help for your child? If you're still struggling with this question, quickly answer this simple list of questions:

1. Has a teacher, friend or relative suggested your child needs professional help?
2. Do you feel that you're at your wits' end, that you can't handle the problem on your own?
3. Do you worry about your child most of the time?
4. Have you been dealing with the problem for 6 months or more without improvement?
5. Has the problem hurt your child's schoolwork, made it difficult for him or her to make friends, or led to constant conflict in the family?
6. Do your child's problems seem very much worse than the problems of other children of his or her age?

If you answered yes to one or more of these questions, the chapters in Part II will help you figure out what diagnosis or diagnoses might apply to your child. And in Part III you learn how to prepare for an evaluation by a health professional.

At this stage, don't get too worried. A single "yes" does not mean your child has a disorder. It only means that further investigation is worthwhile. After reading the rest of this book, you will be very prepared to take your child to the appropriate health care professional. By providing the professional with comprehensive information, you will be better able to help him or her decide whether a diagnosis is warranted.

DIAGNOSING YOUR CHILD'S PROBLEM: A PROFESSIONAL EVALUATION

In Chapter 1, I described the five psychological problems of childhood: disruptive behavior, moodiness, fear, learning impairments, and pervasive abnormalities of development. These five categories give doctors a useful method of classifying childhood psychological problems, and they can help parents articulate, for themselves and any doctors they consult, what they observe that concerns them about their child. But these broad classifications are not enough to get your child the help he or she may need. If something seems wrong with your child, if his or her problems seem to push against the boundaries of what is normal, or if they cause distress and disability to your child or your family, you need a professional diagnosis.

Why? Because diagnosis guides treatment. If your child has a disorder but is not diagnosed with that disorder, he or she will not be treated for the disorder. As a result, your child will suffer unnecessarily. Worse than that, if he or she is diagnosed incorrectly, your child will receive the wrong treatment, which could further complicate problems. If there is only one thing you learn about diagnosis, let it be this: The correct diagnosis leads to the correct treatment; the incorrect diagnosis leads to the wrong treatment. Therefore, taking the time to find the correct diagnosis is essential to avoid unnecessarily prolonging your child's psychological problems.

What does the word *diagnosis* mean when applied to the psychological problems of children? In medicine, a diagnosis is a physician's conclusion about what is causing a patient's complaints. For example, suppose you visit your physician after you've been bothered by a headache, fever, and chills for a few days. The physician asks you questions, orders some laboratory tests, and then tells you something like "You've got a virus. Stay in bed, drink plenty of fluids, and use Tylenol for pain relief." What you don't know is that, having asked you many questions and performed many tests, your physician has also ruled out other diagnoses. You don't have a bacterial infection, migraines, or other possibilities he or she may have considered.

Because most of us deal with the physical health care system long before we deal with the mental health care system, we tend to equate diagnosis with cause: A virus has given Jacob a fever; Patty's

fever is due to bacterial infection. Sarah's arm hurts because she fell and broke a bone; Trevor's arm hurts because he strained a muscle pitching baseball. Thinking about diagnoses as causes works for physical problems, but it does not work so well for psychological problems. The reason, as we'll discuss in Chapter 3, is that we know very little about the precise causes of psychological problems.

For example, attention-deficit/hyperactivity disorder (ADHD) is a childhood psychological problem used to describe children who are inattentive, impulsive, and hyperactive. It's not correct to say that ADHD causes inattention, impulsivity, and hyperactivity, because ADHD is simply a shorthand to describe children who exhibit these behaviors. Unlike many physical diagnoses, the diagnosis of ADHD does not tell you that your doctor has identified a specific cause for these problem behaviors.

Instead of thinking about diagnoses as causes, it is better to think about them as leading to guidelines for treatment: Patty's bacterial infection needs an antibiotic, Jacob's viral infection does not. Sarah's hurt arm needs a cast, Trevor's does not. In addition to providing a guide for treatment, a diagnosis helps health professionals communicate with one another. If your family physician diagnoses your child with ADHD, other family physicians and mental health professionals will know what that diagnosis means without having to ask you the many questions used to find the diagnosis the first time.

A diagnosis should also give you some idea of what to expect in the future. Will your child's problems improve with the right treatment? Will they worsen? Will they be complicated by other problems? Please understand that mental health professionals do not have a crystal ball, so they cannot tell you with complete certainty what the future will bring. They can, however, give you a general idea of what scientists and clinicians have learned about the future of children having the same diagnosis as your child.

Many parents are nervous and even scared about the idea of having their children diagnosed by a mental health professional. They worry that they will learn some horrible truth about their children, that they will be blamed for the children's problems, or that their children will be stigmatized as "crazy" or "mentally ill." It's natural to be worried that your child might be "labeled" forever, but such concerns are based on a misunderstanding of several key points. A diag-

nosis describes your child at one point in time. With time, treatment, and development, diagnoses can change. Some kids outgrow ADHD; episodes of depression can be cured, and most childhood fears do not survive into adolescence.

Parental worries about diagnosis are understandable but usually exaggerated, so please don't let them prevent you from helping your child. In fact, most parents experience some relief after their child has been diagnosed. For example, you may be relieved to find out that your child's problem is relatively minor and is likely to improve with time and treatment. Or, if your child's problem is more severe, knowing what potential problems are lurking on the horizon of life can ease the anxiety that comes from uncertainty and empower you to prevent them or limit the damage they wreak on the child and family.

To sum up, diagnoses of your child's psychological problems will not tell you the problem's ultimate cause. Think of them as tools you will use to ease the distress and disability caused by your child's problems. These tools give you guidelines for treatment, a means of communicating the nature of the problem to all the professionals who will be helping your child, and some idea of what the future will bring. But like any other tool, you can use diagnoses effectively only if you understand how they work—what goes into making an accurate diagnosis and how each diagnosis captures the pattern of thoughts, emotions, and behavior you've been seeing in your child.

Diagnostic Criteria: Professional Standards That Help Your Child

To help you understand how various diagnoses reflect the group of symptoms displayed by a particular child, the chapters in Part II describe diagnoses that fall into the five main groups of child psychological problems described in Chapter 1: disruptive behavior, moodiness, fears, learning problems, and pervasive abnormalities of development. A diagnosis is made up of two parts: a list of diagnostic criteria and a method of combining these criteria to form the diagnosis. The diagnostic criteria are descriptions of the child's behaviors (e.g., he steals) or internal states (e.g., she is frequently nervous). They take into account all the factors that you have already looked at

regarding your child's problems: signs and symptoms, frequency, duration, severity, distress and disability, and how the child in question compares in this area to others of the same age. The rules tell you the pattern and number of complaints that lead a professional to conclude that a child should be given the diagnosis. I derived the diagnostic descriptions in Part II from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV). Use these descriptions to get an idea of where your child's problems may lie and to review any diagnosis you are given by a health professional. I don't expect you to become an expert diagnostician, but I do want you to know enough about diagnoses to be able to evaluate and understand the diagnoses given to you by a health professional.

Most DSM-IV diagnoses are precisely specified. For example, the diagnosis of major depression requires that at least five of nine possible signs and symptoms be present during a 2-week period. If the patient has only four, the diagnosis should not be made. If he or she has nine symptoms for less than 2 weeks, a diagnosis of major depression would be wrong. One of these criteria specifies that fatigue or lack of energy occur "nearly every day." If this symptom occurs only 3 days out of the week, the criterion has not been met. Another criterion asks if the patient has gained or lost more than 5% of his or her body weight. If the weight change is less than that, it simply does not count toward a diagnosis of major depression.

These rules are not arbitrary. They are created by committees of mental health professionals chosen by the American Psychiatric Association. They look over all available scientific research and clinical wisdom and use this information to create the best set of rules for each diagnosis. Because separate committees are set up for different disorders, this process is very well informed by experts in the field. Moreover, when a DSM committee decides to make changes to a diagnosis, the validity of these changes is examined in a research project that applies the new criteria to actual patients. The committees then use the results of these research projects along with everything else known about the disorder to decide on the best possible diagnosis.

For most disorders the final criteria are determined by a research study in which a large set of criteria are tested. The goal of the field

trial is to figure out which criteria are best. A good criterion has several features: (1) It is easy to measure; (2) different doctors can agree most of the time on whether the criterion is present or absent; (3) the criterion is very common among people who have the disorder according to an expert; and (4) the criterion is not usually seen among people who do not have the disorder, according to an expert.

The committee then needs to decide how many criteria should be used and how they should be combined. As you will see in later chapters, different approaches have been used for different disorders. But these approaches share a common method. They seek to create diagnostic rules having the following features: (1) Different doctors can agree most of the time on whether the diagnosis is present or absent; (2) the rules used for diagnosis agree with the opinion of an expert; and (3) the rules create a diagnosis that has important implications for the course, outcome, or treatment of the disorder.

The fact that the current edition of the DSM is the fourth tells you that DSM diagnoses are not written in stone. They improve with time as new scientific information becomes available. For example, an early edition of the DSM would not allow doctors to diagnose panic attacks if these occurred only while the patient was depressed. Later, research showed that this did not make sense. So the current DSM does not include that restriction. Sometimes such improvements lead to a change in the name of the diagnosis. For example, what DSM-IV now calls attention-deficit/hyperactivity disorder (ADHD) was called hyperkinetic reaction of childhood in DSM-I and DSM-II, and attention deficit disorder (ADD) in DSM-III. The improvements to the diagnostic manual usually do not lead to dramatic changes in the number of children who qualify for a diagnosis or what their exact diagnosis would be. But because these changes affect some children, it is important to be sure that the practitioner evaluating your child's psychological problems is up to date and thoroughly familiar with current diagnostic standards.

The chapters in Part II will tell you about the DSM diagnoses that are most important to your child. By learning this new information and keeping your mind open to all possibilities, you will be better able to help professionals diagnose your child. You should expect mental health professionals to be experts in the diagnostic criteria and the diagnostic process. But remember that you are an expert

in your child's behavior, and you are therefore critical to an accurate diagnosis. You have observed your child in many situations over many years. You may have spoken about his or her problems with teachers, principals, friends, and relatives. You know what has and has not worked to change his or her behavior. In contrast, the mental health professional will observe your child for only a short period of time, so don't be shy about expressing your opinion and providing facts about your child. The more information the experts have, the better able they will be to make an accurate diagnosis (and the better you will feel for having done the best you can to help diagnose your child's problem).

One of the best ways you can help your child's doctor is by making sure he or she knows about all your child's signs and symptoms, not just the obvious ones. For example, Alicia was a shy, nervous teenager who had many obvious fears and few friends. When I heard about her main complaints, there was no doubt that she was suffering from an anxiety disorder. But Alicia never mentioned feeling sad or worthless either when talking to me or when taking psychological tests. Fortunately, her mother had come to the evaluation session very prepared. She too was worried about Alicia's nervousness, but she also told me that she frequently heard her crying alone in her room after school or at night, that Alicia frequently described herself in a bad light (as ugly, stupid, unfit for friends, and so on) and that once she had told her father she'd be better off dead. This information led me to ask more questions, which led me to the conclusion that Alicia was also seriously depressed.

Although grouping children into separate categories and diagnosing them with disorders is extremely useful, we must never forget that all children are individuals. Their problems may be similar to those in the same category, but they will also have unique features that should not be ignored. For example, severity differentiates children having the same diagnosis. It's not enough to know that your child has ADHD; you need some idea of how severe his or her case is compared with others. Is it treatable? Will it evolve into something worse? What is the long-term outlook? You will need to work with a mental health professional to determine how these factors apply to your child.

Likewise, the categories we use to describe the psychological problems of childhood are not meant to be mutually exclusive. Scien-

Disturbance, Problem, Disorder, Temperament . . . : Sorting Out the Terms Used before a Diagnosis Is Made

If you didn't notice it yourself, you may have been alerted to your child's problem first by a teacher, social worker, school counselor, pediatrician, or someone else who sees your child on a regular basis. That person may have used terms such as *emotional disturbance, behavior problems, extreme temperament,* or *psychological problems* to describe your child. Because these terms are so often used incorrectly by the media and by nonprofessionals, you may not be sure of what they mean when applied to your child.

The terms *emotional disturbance, behavior problems, extreme temperament,* and *psychological problems* share one thing: They are used to describe children who are experiencing difficulties but do not necessarily signal that these difficulties are severe enough to qualify as an illness or disorder. A teacher may use such terms to urge you to seek a professional evaluation, or you may hear these terms used during the early stages of an evaluation, when the practitioner performing the evaluation is not yet sure of the specific nature of the problem. These terms are also useful to describe children who have mild problems that are not mental disorders. No matter who uses them, always seek clarification of what the speaker means by them.

The term *emotional disturbance* usually means the child is experiencing unpleasant feelings such as fear, nervousness, and sadness. When the term is used to describe kids who get into fights, break things, intrude on others, or are otherwise disruptive, the person using the term usually means that underlying feelings are causing the disruptive behavior. But this usage is not correct. It is more accurate to describe children who are disruptive as having *behavior problems*. This phrase means exactly what it says. The child's behavior is causing problems at home, at school, or among friends.

Temperament refers to any of the many psychological traits of all children. For children, this word is used in everyday language in much the same way the word *personality* is used for adults. It represents traits that describe the child's overall style of dealing with other people and changes in the environment. One example is sociability. Some kids are very shy and withdrawn. They dislike meeting people and have a difficult time making friends. Others are bold and sociable. They approach strangers with comfort and make friends with ease. Most kids fall somewhere in between. Sociability is not an either/or category. It's a trait that varies from very, very high, to very high to somewhat high to average to somewhat low to very low to very, very low.

We say a child's temperament is extreme if it falls in either of the

very, very low groups. Sometimes extreme temperament does not cause problems and may even be good. The outgoing, talkative child who easily makes friends will have many social advantages in life. Parents worry about very shy, withdrawn children because their shyness prevents them from participating in many of the enjoyable activities of childhood.

The term *psychological problems* is a broad term that includes emotional disturbance, behavior problems, and extreme temperament. Like these terms, it is used to indicate that something is not quite right with the child's psychological make-up, that he or she is experiencing some unusual difficulties with emotions, thinking, or behavior that may need professional help.

A *mental* or *psychiatric illness* or *disorder* is a pattern of problems in the areas of emotion, thinking, and behavior that fits into one of many categories known to doctors as conditions that cause distress and disability in children. While children who have psychological problems may not need treatment (though many can, in fact, benefit from it), children who have mental disorders usually do. No one should use the term *disorder* in reference to your child unless the child has received a professional diagnosis.

tists have now established, without a doubt, that children who have one mental disorder are at risk for having another. Yes, this is a frightening thought, but it should not deter you from your ultimate diagnostic goal: to understand the full range of disorders suffered by your child. I cannot overemphasize how crucial it is that your child be diagnosed correctly. Professionals use diagnoses to plan treatment programs. If the diagnosis is wrong, the treatment will be wrong. It's that simple. Please do the best you can to assure that your child is diagnosed correctly. Start by keeping an open mind. Don't let popular myths about mental health care prevent you from seeking the help that your child may need.

MYTHS ABOUT THE PSYCHIATRIC DIAGNOSIS OF CHILDREN

Psychiatry and psychology deal with many intriguing issues that raise fundamental, personal questions. This fascination makes mental health

a popular media topic and, unfortunately, media coverage often leads to misinformation.

It's Just a Phase

At age 5, Johnny was shy and withdrawn in kindergarten. His parents said, "Don't worry. It's just a phase." At age 7, Johnny, still shy, had become chronically irritable. His parents said, "Don't worry. I'm sure it won't last. " At age 9 Johnny began to do poorly in school. His parents said, "Don't worry. This will pass." At age 11, Johnny became sad and moody. His parents said, "Let's not overreact. I'm sure it's just a phase." At age 13 Johnny was caught sneaking a drink of his father's whisky. His parents said, "Don't worry. Everyone does it at this age." At age 15 Johnny's moods became darker, his self-image worsened. His parents said, "Don't worry. He's a teenager after all." At age 17, Johnny was hospitalized for depression. His parents were speechless with grief.

Johnny's story is extreme but all too possible. It's easy to persuade ourselves that our child is "only acting his age" or that problems will go away in time. After all, most kids go through the terrible twos, many get in trouble at school at some point, many roughhouse with friends, and lots of teens are moody and experiment with drugs. Most, fortunately, outgrow this behavior. But what about those who don't?

Most parents have no way of knowing whether their child is going through a phase or has a problem that needs to be addressed. You can go through the exercise of roughly measuring a problem you observe in your child, as described earlier in this chapter, but you are not going to get a definitive answer to the question "Is this just a phase?" unless you consult someone with more experience and training.

I'm not suggesting that you get all worked up every time your child misbehaves or does something unusual or that you rush off to a psychiatrist or psychologist whenever your child's behavior perplexes you. My recommendation is that you seek advice from your pediatrician or your child's teacher. Because pediatricians and teachers have seen many children, they are good at separating normal phases from worrisome behavior. Most parents speak with these pro-

fessionals on a regular basis. If something seems wrong with your child, don't dismiss it outright as "just a phase." Talk to a teacher or doctor about your concerns. In most cases they'll tell you not to worry. But seeking such preliminary advice might catch a more serious problem at an early stage. That can only benefit your child in the long run.

If your pediatrician or the teacher says he or she thinks you have reason to be concerned, educate yourself about the psychological problems of childhood, starting with Chapter 1 of this book. If what you read confirms your concerns and you decide to seek professional help, don't be put off by a pronouncement from a doctor that "it's just a phase." If you find yourself in this position, you must remember that doctors are not always right. You should certainly listen to your doctor and ask questions so you can understand his or her point of view. But if he or she cannot convince you, you should seek a second opinion from another doctor.

It's Just Bad Parenting

It angers me to hear one of TV's talking heads claim that this or that childhood disorder is due only to bad or lax parenting. You may have heard these claims. A typical one is "We didn't have ADHD in the 1950s when family units were strong and parents knew how to discipline misbehaving children." This statement is plain wrong. Although the term ADHD was not used in the 1950s, these children were known by teachers and treated by doctors for the same types of problems we see in ADHD children today. In fact, the first stimulant treatment of ADHD was discovered in 1937.

I'm not criticizing people who yearn to return to an era of family values, intact families, and rigid discipline. These are cultural beliefs that are held by many. What I am arguing with is the reasoning behind the claim that sociocultural changes are responsible for the symptoms we associate with ADHD. The fact that there has been a decline in family values and parenting over the past four decades and that there has been an increase in children diagnosed with psychiatric disorders in the same time period does not mean that one caused the other. Correlation is not the same thing as cause and effect. Teasing out cause and effect is a difficult task. Without scientific stud-

ies, we can draw no conclusions from simple observations of change over time. As you'll see in Chapter 3, scientific studies show that parents don't cause childhood disorders. They can make these disorders worse by not seeking treatment or by creating a chaotic home environment, so parents do need to be aware of the home environment they create for their children. But they shouldn't berate themselves for having caused their child's problems.

Here's an example that shows how teasing apart cause and effect can be a tricky matter. One of the treatments for ADHD is parent management training (see Chapter 11 for details), which teaches parents how to use rewards, punishments, and rules to better control their child's behavior. Because parent management training improves child behavior, some psychologists concluded that the disorder was caused by bad parenting.

One study looked at this issue another way. It treated ADHD children with medicine and found that it improved their behavior. At the same time, the study investigators observed parents to see if they were using good parenting methods. Surprisingly, they found that after the medicine improved the child's behavior, the parents became better parents. That is, they began to use better methods of parenting. This study suggested that having a difficult child makes it difficult for parents to use good methods of parenting. The moral of the story is that sometimes what appears to be a cause is really an effect and vice versa.

Don't let concern that you'll be blamed for your child's problems keep you from consulting the professionals who can help. If you get the feeling that a professional you consult is blaming you for your child's problems, ask for clarification first, to be sure you haven't misunderstood. If the feeling persists, find another doctor.

Psychiatric Diagnoses Are Not Objective

According to this theory, mental health professionals diagnose disorders based on subjective whims rather than objective criteria. This misunderstanding arises from fuzzy thinking about what is and is not objective. Critics of the mental health professions consider a diagnosis objective only if it is made using a laboratory test. They would not criticize a diagnosis of epilepsy made by measuring brain waves with

an electroencephalograph, but they would view questions about whether the patient has ever had the signs and symptoms characteristic of an epileptic attack too subjective to serve as the basis for a diagnosis. In fact, epilepsy is usually diagnosed not by measuring brain waves but by asking patients about their symptoms.

With regard to symptoms or diseases, *Webster's* defines *objective* as "perceptible to persons other than the affected individual." As you'll see in Part II, the signs and symptoms of psychiatric disorders meet this definition. Consider the symptoms of depression. When a teenager tells a doctor, "I've been so unhappy this past month I thought maybe I should kill myself," the doctor objectively recognizes the statement as a symptom of depression. Now consider symptoms of a heart attack. When an emergency room patient tells a doctor, "I've got a pain in my chest that shoots down my left arm," the doctor objectively recognizes this statement as a symptom of a heart attack.

Thus, it's not necessary for doctors to have a laboratory machine or a blood test to diagnose a disorder. What they need is a method of diagnosis that is systematic and carefully defined. The use of careful definitions means that psychiatric diagnoses are not arbitrary. If one doctor diagnoses the disorder, it's very likely that another will diagnose it as well. I'm not saying that two doctors will always agree about a patient's diagnosis. Some cases are challenging and difficult to diagnose. Fortunately, for most cases there is good agreement.

Psychiatric Disorders Are Overdiagnosed

There's been a lot of loose talk in the media about psychiatric diagnoses. We read stories with titles like "Milk, Cookies and Prozac" that imply that doctors have medicalized the everyday problems of life. Children are depressed, not sad. We say they have oppositional defiant disorder when we should punish them for being bratty. We say they have ADHD when parents and teachers have been too lazy to do their jobs.

These are harmful myths—harmful because they downplay the severity of childhood mental disorders, harmful because they blame parents and teachers for complex problems that are not their fault. They all derive from a common illogical line of thinking that goes like

this: (1) Child psychiatric disorders used to be rare, (2) now they are common, so (3) doctors are making big mistakes these days.

Points 1 and 2 are true enough. Thirty years ago many fewer children were diagnosed with any psychiatric disorder, and some, like mood disorders, were diagnosed rarely, if ever. Today, as you can see from the examples in the Table 2.2, child psychiatric disorders are fairly common. It would be a mistake to add the figures in the table and conclude that more than 30% of kids have one of these disorders. That's because most kids who have one disorder also have another. Studies that have looked at many disorders in children tell us that about 20% of kids (that's one in five) will have a psychiatric disorder.

When these studies look at who gets treated, they find that many of the children who have disorders have never been diagnosed and treated. They also find that some children who did not have diagnoses were being treated for one by a doctor. When we put these two pieces of information together, they tell us that doctors do not have a bias to overdiagnose psychiatric disorders in children. Instead, sometimes they make mistakes by not noticing a disorder that exists or by making a diagnosis when the child does not qualify for the disorder. They also suggest that many parents do not notice the signs of mental disorder or don't realize that they should seek treatment for their child.

This is a good time to discuss an obvious but important point. Like you and me, doctors are human and make mistakes. That is one of the reasons I've written this book. The more information you have

TABLE 2.2. Percentage of Children Having Psychiatric Disorders

Attention-deficit/hyperactivity disorder	5–10%
Conduct disorder	2–5%
Depression	2–5%
Phobias	5%
Separation anxiety disorder	4%
Generalized anxiety disorder	5%

about your child's problems, the more likely it is you will avoid the mistakes that sometimes occur.

"Labeling" Children Stigmatizes Them

Before the advent of modern medicine, people with mental disorders were ostracized. Folklore described them as possessed by the devil, morally corrupt, victims of witchcraft, or punished by deities. Although, as we enter the 21st century, such beliefs are distant memories, stigma continues to harm people with mental disorders. Today, stigma comes in many forms.

On the personal level, mentally ill adults have described losing friends, jobs, or other opportunities after they've been open about their having a mental illness. In schools, some children must go the nurse's office to take their medication in the afternoon. Other kids soon learn that this medication is for ADHD or some "mental" problem. Some of those other kids ridicule or reject the children receiving treatment.

Some parents worry that their child's psychiatric diagnosis will follow him or her for the rest of his or her life. How will they answer those nosy questions on college, job, or insurance applications: "Have you ever been treated for mental illness?" "Have you ever had psychotherapy?" If they tell the truth, will it hurt their future? If they lie, will they make matters worse?

Stigma is real. People have been denied jobs, entrance to medical school, or advancement in their career, not because they could not handle the work, but because they had been diagnosed with a mental illness. Even the powerful are not immune to stigma. During the 1972 presidential race, presidential candidate Walter Mondale nominated U.S. Senator Thomas Eagleton for vice president. Later, Senator Eagleton disclosed that he had been treated and hospitalized for a mental disorder. After the usual feeding frenzy of the media, the senator stepped down when he realized that his psychiatric history would hurt Mondale's chances of being elected.

About 10 years ago, a worried mother asked a past president of the American Psychiatric Association how her son, who had been treated for a psychiatric disorder as a teen, should handle college application forms that inquired about such treatment. The doctor, being

a realist, replied, "I would tell them to lie on the forms. The stigma is there, and to deny it and sacrifice yourself by telling the truth makes no sense. With the public at large I work to decrease stigma, but with individual patients I impress on them how widespread and deeply rooted the stigma is. If two people who are equal in credentials apply for a job and one has had psychiatric treatment, that person will be discriminated against, and he'll be the loser in the competition for the job. Even if the person with treatment had better credentials, he most likely still would lose out to the other person. That's how deeply rooted the stigma is. I will not encourage anybody to acknowledge that they had treatment."

Fortunately, campaigns to end stigma are succeeding slowly but surely. In 1990, the U.S. Congress passed the Americans with Disabilities Act (ADA), which protects people with either mental or physical disabilities. Compliance with these guidelines by businesses and schools is mandatory. Because of ADA, it is no longer legal for job or school applications to inquire about prior psychiatric diagnoses or treatment. If a mental disorder impairs job performance, employers must take "reasonable" steps to make accommodations for those impairments. Examples of accommodations are extra time off from work and changes in scheduling.

The antistigma campaign drew great strength from Tipper Gore, the wife of our former vice president. Ms. Gore, who has publicly acknowledged her treatment for depression, organized meetings around the country aimed at developing policies and educating Americans about mental illness. At a White House conference on mental illness, former President Clinton made fighting stigma a key feature of his mental health policy.

Someday, people will view mental illness no differently than they view physical illnesses. Today, parents must wrestle with stigma when they consider having their child evaluated for a mental disorder. Should stigma affect a parent's decision to seek help for a child? I say no. Don't force your child to suffer the distress and disability of a mental disorder. He or she should not be denied helpful treatments. But be aware of stigma. Don't publicize your child's illness, except as necessary to get the type of help he or she needs at school. If you do share your child's story with teachers or other caregivers, also share

your concerns about stigma so they can do their part to respect the privacy that your child deserves.

Children with Psychiatric Diagnoses Are Doomed to Failure

Because of stigma, many parents avoid or delay seeking help for their child because they fear the doctor will give them very bad news. Unfortunately, the phrases "mental illness" and "psychiatric disorder" conjure up made-for-TV images of mental hospitals filled with "crazy" patients who must be locked up because they are a danger to themselves or the community. The idea of mental illness conjures up words such as "insanity," "madness," and "lunacy," words that today express society's misconceptions about mental illness.

I won't deny that some mental disorders, especially when not treated, lead to severe levels of disability. In the most severe cases, hospitalization is required. But these severe cases are the rare exception. Most children with psychiatric diagnoses have relatively mild problems that, if treated, will not markedly affect their ability to live happy and productive lives.

Consider some examples. General George Patton couldn't read at age 12. He probably had an undiagnosed learning disability, but his intelligence and strong character helped him become highly successful. Albert Einstein's developmental delays—he couldn't talk until age 4, couldn't read until age 9, did poorly in math and written language, and failed his college entrance examinations—didn't prevent him from becoming a brilliant physicist. Thomas Edison, labeled "addled" by his teachers, was a sloppy, inattentive, and distractible boy who may have had ADHD but went on to invent the light bulb, phonograph, and numerous other marvels that changed the lives of millions of people.

Having a psychological problem or even a mental disorder does not doom a child to misery and failure. A "disorder" is merely a description of problems, problems that often can be overcome by countervailing strengths. A "disorder" does not summarize all the child's traits and abilities any more than knowing his or her hair color and weight summarizes the child's physical description.

If your child has psychological problems, don't delay getting

help for fear of dealing with a diagnosis. If he or she is diagnosed, remember that your child's strengths of character, emotion, physical dexterity, academic achievement, intellectual skill, or interpersonal prowess are as much a part of him or her as any psychological problems.

In the next chapter you'll learn about what causes psychological problems in children. Our understanding of psychological problems was advanced significantly during the last three decades of the 20th century, when new technology made it possible to pinpoint defects in brain structure and function and, at the same time, medical research discovered medicines that corrected some brain defects. As I'll explain in Chapter 3, this information led most mental health professionals to conclude that many psychological problems are caused by brain disorders. In fact, the National Institute of Mental Health declared the 1990s the Decade of the Brain. With this new understanding, much of the stigma surrounding mental health problems has evaporated, and many more kids are getting whatever help they need.

Chapter 3

What Causes Psychological Problems?

"Why does my child have psychological problems?" is one of the first questions that parents ask when they consult a mental health practitioner. It's also one of the most complicated to answer. The vast majority of psychological problems cannot be explained by one, two, or even three factors. Instead, they arise from many biological, psychological, and social events. When your child has reached a point of distress and disability that makes you worry that something is seriously wrong, it is almost always because these events have, one after the other, accumulated to degrade your child's psychological health.

This means, unfortunately, that you probably won't be able to pinpoint one factor that is responsible for your child's problems and can be eliminated to solve them. Few psychological disturbances in children are caused by a lurking virus, an operable brain tumor, an environmental hazard, or a toxic diet. The good news is that the complexity of cause in psychological problems also means you can't blame yourself for your child's difficulties. Most parents believe to one degree or another that they are at fault if their child has mental, emotional, or behavioral problems. Are you concerned that you might be a bad parent? Convinced that your spouse is a poor parent? Do you feel guilty about not having spent more time reading to, playing with, or listening to your child? Do you think you were too lax with discipline? Too strict? Inconsistent? Was it your failure to end your son's

friendship with your delinquent neighbor? Was he enrolled in preschool too early, too late, not at all?

The truth is that parenting, as an important facet of any child's environment, naturally plays a role. But it is more likely to contribute to what kind of impact the core psychological problem has on the child's life than to the creation of the core problem. As I've seen time and time again, parenting certainly contributes to how well any treatment works for an individual child. In other words, you may or may not be part of the problem, but you are definitely part of the solution. Chapter 12 offers practical suggestions for becoming part of the solution, and the sidebar on pages 89–91 provides a more thorough explanation of why it doesn't make sense to blame yourself for your child's problems. For now, though, if parenting isn't to blame, what is?

WHAT WE KNOW AND DON'T KNOW ABOUT CAUSE: AN OVERVIEW

If the causes of psychological problems were a jigsaw puzzle, then I'd say that over the last few decades we have finally identified most of the pieces but have a long way to go before we'll know exactly how they fit together. These pieces include neurochemistry and brain structure, genetics, physical illness, environmental stress and adversity, and the child's innate resilience. We know from innovations in brain imaging technologies that some children who have certain psychological problems have abnormalities in the structures of the brain. We know from the effectiveness of medications that change the balance of neurochemicals that problems with the brain's chemical messengers are associated with psychological disorders. We know that many psychological disorders run in families or appear much more commonly in identical twins than in nontwin siblings, so there must be some genetic cause. But we also know that when one twin has a disorder, the probability that the other identical twin will also have it is not 100%—which means the environment must play a role in who ends up with a disorder even if it is heredity that predisposes people to it.

Most scientists today believe that the key to how all these pieces

fit together lies in the brain. Since as far back as the middle of the 19th century, we've known that people with documented brain damage have psychological problems. We also know, first from examinations of the brain following death and in more recent years through brain imaging technologies that allow us to look at the living brain, that many people with psychological disorders have abnormalities of brain structure or function. Finally, we know from reams of clinical evidence that medicines that alter the chemical environment of the brain can alleviate psychological disorders. The track record of medications like Prozac for treating depression, Xanax for anxiety, and Ritalin for attention is compelling.

All of this is not enough, however, to prove a simple and direct cause-and-effect relationship. Some information we have raises questions about how and when brain abnormalities associated with psychological disorders occur. We know, for example, that brain scans of people with obsessive–compulsive disorder (OCD) show that they often have abnormalities in the circuits linking the basal ganglia to the cortex. The same scanning technologies show a return to normal in these circuits when medication that targets neurochemicals improves the patient's OCD symptoms—an effect we would expect if malfunctions in brain circuits were the cause of OCD. But scans also show a return to normal in these circuits when the patients' symptoms are treated effectively with cognitive-behavioral therapy. This suggests that there may be several ways in which these brain abnormalities can be both caused and cured.

Where do the abnormalities come from in the first place (if not from a direct assault on the brain via injury or physical illness)? As far as we know, the root cause could be genes or the environment; odds are it's both, in varying combinations in different people. We still have a lot to learn, of course. We don't know which genes predispose people to certain disorders, nor do we know which environmental influences carry the most weight in turning a predisposition into an actual disorder. We don't know how developmental factors come into play—whether there is a particular age at which a child might be especially susceptible to environmental stressors that can activate a predisposition or when abnormalities in the brain appear during the developmental path that every child traverses. All of these questions are the focus of extensive, ongoing research.

HOW WE CAN USE OUR UNDERSTANDING OF CAUSE

Realistically, then, it may not be possible to identify the exact factors that have caused your unique child to have psychological problems. A general understanding of how psychological problems work, however, will help you grasp why a doctor may recommend certain treatments, will help you maintain proper perspective during treatment, and will help your child get the best benefit from prescribed treatments. A doctor may suggest Prozac for a child's depression because a serotonin imbalance is associated with depression and because Prozac has been seen to alleviate the symptoms of depression, even though we still have much to learn about what causes depression and exactly what total effects Prozac might have on the brain. Knowing that neurochemical imbalances are probably not the sole cause of depression will prevent you from expecting Prozac to work on depression the way amoxicillin works on strep throat. Understanding that depression is often triggered by life changes or stressful events will help you modify your child's routines and family life as necessary to ensure that he or she gets the most out of whatever treatment is prescribed.

What causes psychological problems, and how the causes are connected to effective treatments, may never be as straightforward as for physical illness. Strep throat is caused by a bacterial infection. When the child is treated with antibiotics, the infection clears up and the sore throat and fever go away. It's not so simple with psychological problems. Prozac alleviates many of the symptoms of depression for many people, but the fact that Prozac corrects a neurochemical imbalance (serotonin in particular) does not mean that the problem with serotonin is the root cause, or the only cause, of depression in an individual. Prozac may ease the debilitating symptoms of a major depression (described in Chapter 5), but does it mean that the child is no longer predisposed to depression? We don't think so. Does it mean that the child won't become depressed again if the Prozac is stopped? That depends on a myriad of other factors, including what triggered the child's depression to begin with and other environmental factors. As a parent who wants the best for your child, it's just as important—maybe more important—that you understand the ques-

tions that we're still struggling with as that you know the answers we've found.

The rest of this chapter goes into more detail on what we currently know about the factors involved in cause—not to provide a map that will allow you to trace the precise causes of your child's problems but to give you a solid grasp of how psychological disorders work: how the brain governs the mind, when physical illness might come into play, how to look at the complexity of the environment and its effects on your child, and the different ways that heredity seems to contribute to various psychiatric disorders. I hope that this knowledge will help you help your child and your family.

PSYCHOLOGICAL PROBLEMS AND THE BRAIN

The last half of the 20th century witnessed a major shift in how scientists view psychological problems. For many years, psychiatric disorders were treated mainly via "talk" therapy, based largely on Freudian theories about the roles of the conscious and subconscious mind. (Exceptions were those psychological problems caused by physical problems, such as when a malfunctioning thyroid gland causes the signs and symptoms of depression.) Toward the end of the 20th century, however, the ability to view brain activity through new imaging technologies revealed that events that occur in the mind—such as thinking, feeling sad, and having dreams—are associated with specific types of activity in the brain. These new technologies, such as functional magnetic resonance imaging and positron emission tomography, can show not only which parts of the brain go to work when people see, hear, think, feel emotions, and experience other psychological events, but also how much activity occurs. They left no doubt that whether we respond to situations with pleasure or pain, sadness or mirth, anger or calm depends on the type of brain activity evoked by the situation. For every psychological experience, there is an underlying brain event. It was then only logical to speculate that if sadness, for example, had a corresponding brain event, perhaps pathological levels of sadness such as depression were caused by physical changes in the brain.

How Complex Defects in the Brain Can Produce Psychological Problems

There are three basic steps involved in brain functioning: sensation, the brain's decision, and action. When we hear, see, smell, taste, and touch things in the world around us, our nerves send signals to the brain. The brain then processes these signals and instructs the body on what action to take. In this context it's easy to see psychological problems as brain problems. When the brain makes a wrong decision, a problem—either physical or psychological—ensues. Consider a child whose brain signals his body to touch a hot stove, an error of brain functioning. If the same child has been known to run into the street without looking for cars, to say whatever pops into his head no matter how inappropriate, to hit first and ask questions later, his parents might describe him as a boy who "acts without thinking." A doctor would say he shows the symptom of impulsivity. A neuroscientist would say the brain circuits that stop dangerous behavior do not work correctly. The brain is deciding to move the child forward rather than stopping him.

The brain is built from nerve cells, which send chemical signals to one another. When the child feels the heat of the stove, a signal is sent from heat sensors in the skin to the brain, where it combines with many other signals. Some of these other signals are recording other sensations. Others are recalling memories of past experiences with heat, and still others are recording a feeling of excitement at doing something new and forbidden. These are only a small fraction of the signals the brain handles at any given moment. The human brain contains between 100 million and 200 million nerve cells, each of them sending signals to 10,000 or more other nerve cells. Scientists estimate that there are about 10 trillion connections between nerve cells in the human brain. If we could lay these tightly packed nerve cells end to end, they would stretch for more than 250,000 miles. No wonder this extremely complex organ uses up 20–30% of our energy even though it makes up only about 2% of our body weight.

It's also no wonder that a wide variety of psychological disorders could result from a faulty signaling system—and that any disorder could have complex causes within the brain. If you look at just the messages communicated between two nerve cells, you'll see that a

number of different problems could occur, resulting in a number of different types of errors being factored into the brain's decisions.

When nerve cell A wants to speak to nerve cell B, it releases certain chemicals, called neurotransmitters. When a chemical from cell A lands on a receptor on cell B, the receptor creates an electrical signal in cell B. If that signal is strong enough, nerve cell B will release chemicals to communicate with other nerve cells. But let's say the process goes awry. Maybe nerve cell A cannot signal B because A cannot create the chemical message. Or maybe cell A can create the chemical message, but cell B has no receptors. Another possibility is that A can signal B, but the signals are weak because A produces fewer chemical messages than normal and B has fewer receptors than normal. Any of these problems could result in a psychological problem, such as a learning disability. But it's likely that tens of millions of nerve cell connections are involved in reading and that many different types of chemical messengers and receptors are used to make these connections. Imagine that there are five types of messengers and five types of receptors. Assume a weakness in any one messenger plus a defect in any one receptor leads to a reading disability. Then there would be twenty-five different combinations of nerve cell defects that could cause learning disabilities. In fact, reality is even more complex because scientists must consider not only messengers and receptors but also many "helper chemicals" needed for one nerve cell to communicate with another.

Neuroscientists have made great strides in understanding how brain circuits control our psychological life. They've even created maps of the brain that tell us what parts of the brain control which different aspects of our psychological world. They know that directly under your skull there is a strip of nerve cells running from your left temple to right temple. This strip of cells activates when we feel sensations on our skin. Another strip of nerve cells a bit closer to the forehead sends out signals that command our muscles to move. We know which part of the brain handles each of the five senses; we know which parts handle emotional experience and which deal with memory.

Thanks to brain imaging methods that can take three-dimensional pictures of the brain, we can also measure the sizes of different parts of the brain. Structural magnetic resonance imaging can tell us

if patients have brain structures that are too large or too small or if the brain has been attacked by tumors or strokes. For example, the brain structures that regulate attention and activity tend to be smaller in children with attention-deficit/hyperactivity disorder (ADHD). They can also show us which regions of the brain turn on when a person is asked to do a specific task, like remember a list of words. By comparing the films of the brains of people with and without psychological disorders, we can see which regions of the brain may be causing the disorders. These films are beginning to produce some intriguing information. People with ADHD show weaker functioning in the very front part of their brain. Children with a reading disability show reduced activity in a language center toward the back of the brain. The more these scans are performed, the more links are revealed between specific disorders and particular abnormalities in the brain.

We've known for a much longer time that damage to the brain can produce physical problems, such as those that result from strokes. In the case of a stroke, a blood vessel in the brain gets clogged, such as by cholesterol, so that blood stops flowing to a small section of the brain and the cells in that area die. Some of those cells might be responsible for telling the victim's leg muscles to allow the person to stand up; others might be telling the person how to speak. Many stroke victims have difficulty walking and speaking following the stroke.

With psychological problems the brain malfunction is much more complicated than the death of certain cells. Although two people with the same psychological problem may share some brain defects, some of their defects will be unique. It's also possible for two people with the same psychological disorder to have completely different defects. It's like having two cars that won't start. One has a dead battery, the other has dirty spark plugs. These two engine defects affect the same mechanical circuit and lead to a common final pathway: The engine cannot create the spark needed to burn its fuel. Scientists think each psychological disorder may have its own common final pathway, which can be affected by many different anomalies in the nerve cells that make up the pathway.

When compared with our knowledge of just a few decades ago, what we now know about what happens in the brain to produce psychological problems is nothing short of astounding. Thanks to these advances, we have medications that can allow children whose future

once looked bleak to attend school, make friends, and live their lives as children should. Thanks to advances in genetics, we are making headway toward preventing some psychiatric disorders altogether. For now, parents can take hope in the fact that many psychological symptoms that were once impossible to control can be managed very effectively, allowing many children to function normally along with their peers.

The future holds even more hope. We know that most psychiatric disorders are developmental in nature rather than acquired. That is, they develop in the brain as the child develops with growth; very few occur due to an injury or other acquired condition. We are also gathering more and more evidence that a major factor in the severity of some disorders is the length of time that the person has had the problem. Multiple episodes of bipolar disorder, for example, may be "toxic" to the brain, perpetuating the illness. In this sense we can say that one cause of a severe, chronic psychological problem is simply leaving the early symptoms alone.

That's why a major direction of future research is the challenge of early intervention. We already know that children who are treated early have less severe mental illness years later than those who are not; in some cases the course of the illness may even be arrested entirely. With illnesses like obsessive–compulsive disorder (OCD), we may be able to change the neurodevelopmental pathway in some children and prevent childhood OCD from becoming a chronic and severe adult illness by teaching kids to resist their compulsions and muffle their obsessions (with a consequent return to normal brain activity). Can we go back even farther along the pathway so that we prevent psychiatric disorders from appearing at all? We're learning more every day about the genes that put some children at high risk for certain disorders. Is there a way to treat children in the at-risk stage that will prevent them from going into the symptomatic stage? One possibility might be to try to improve pre- and postnatal care of children born to mothers with disorders known to be inherited, such as schizophrenia. By optimizing environmental conditions, it might be possible to limit the impact of genes to an extent that would prevent neurodevelopmental anomalies from developing in the first place. Or, if we know what the neurodevelopmental precursors of a disorder are, we might be able to treat the child who shows these

signs with therapy that would keep the full-blown disorder from appearing.

What Causes Brain Defects?

The Role of Genes

Genes play an enormous role in creating brain defects that lead to the symptoms of psychological disorders. Our genes contain all the instructions needed to build our bodies and thus our brains. If a gene gives the wrong instructions, the brain built will not work properly. It might have nerve cells that cannot produce enough chemical messages or others that have faulty receptors. Or it might contain certain structures that are too large, too small, or the wrong shape entirely. When genes build faulty nerve cells or abnormal structures, they create brain defects that cause psychological problems.

While neuroscientists were describing the nature of brain problems among people with psychological disorders, geneticists were conducting research that showed that variants of some genes could predispose people to these disorders. For many years doctors had known that psychological disorders tended to "run in families." Initially, many doctors thought this was because family values and culture, which were transmitted across generations, caused psychological disorders. But studies of twins showed that heredity was much more likely to be destiny than environment was.

The amount of influence that genes have varies among disorders but is usually substantial. Research shows, however, that the nature of the genetic influence on psychological problems is much different from that of genetic influences on incurable, devastating genetic diseases like Huntington's disease or multiple sclerosis. The latter diseases are caused by rare aberrations in one gene that leads to one or more serious malfunctions in the human body. The creation of psychological problems and disorders requires the effects of many genes, each of which has a minor defect. These defects are so minor that most people with the defect are perfectly normal. For example, research shows that one variant of a gene known as DRD4 increases the probability that a person will have attention-deficit/hyperactivity

disorder (ADHD). Yet many people (about one in five in the United States) carry the variant, and most of these will not have ADHD or other psychological problems. Scientists believe that psychological problems occur only when a person has many mildly aberrant genes.

The Role of the Environment

Studies of identical twins have also told us that genes alone cannot explain why some children have psychological disorders. For example, when one twin has ADHD, the likelihood that the other twin also has ADHD is very high, about 50%, which is twice as high as it would have been if the other twin were not genetically identical. Although this finding shows convincingly that genes play an important role in ADHD, it also shows that having the same genes as someone with ADHD does not guarantee that you will have ADHD. There must be more to the story. Enter the environment, the other factor that causes brain defects that lead not only to ADHD but also to other psychological problems.

If psychological disorders originate in the brain, then any feature of the environment that influences brain functioning could influence psychological disorders. Table 3.1 lists some examples. For conve-

TABLE 3.1. Some Environmental Features That May Influence Psychological Problems

Biological	Psychosocial
Toxins	Social adversity
Viruses	Family conflict
Substance abuse	Chaotic parenting
Malnutrition	Peer pressure
Trauma	Social learning
Infection	Bad role models
Head injuries	Stress
Birth complications	Bullying by peers

nience, I've divided environmental influences into two groups: biological and psychosocial. Biological influences are those that act directly on the brain. For example, a child who became unconscious after falling from a tree may have experienced brain damage from the fall. Malnutrition early in life can prevent the brain from developing properly. Toxins such as lead, if eaten, can lead to psychological problems.

Children's brains are especially vulnerable in the period before, during, and directly after birth. If a pregnant mother is malnourished, does not receive prenatal care, or abuses alcohol or drugs, her unborn child may suffer abnormal brain development, which in turn can lead to psychological problems. The brain can also be affected if complications during birth temporarily cut off the supply of oxygen to the child's brain.

The word *psychosocial* refers to any feature of the social or interpersonal environment. Psychosocial influences have an indirect effect on the brain, but these effects are more subtle and occur through either a psychological or social mechanism. Learning is a psychological activity, but for learning to be effective it must change the brain by storing new knowledge. Peer pressure is a social influence that affects values, priorities, and key life decisions. It leads to a form of social learning, which stores social information somewhere in the brain.

It's important to remember that the brain is the final common pathway for psychological problems. Distinctions between mind and brain, physical and psychological, or biological and psychosocial can be useful. But they should be viewed simply as convenient categories for communication rather than true dichotomies.

Stress provides a good example of the link between the psychosocial and the biological. There are two main types of stress: adversity and life change events. Adversity harasses children in many forms: brazen bullies, hard homework, barking dogs, abusive parents, death of a pet, failure in school, and so on. It's easy to see how such adversity can hurt the emotional state of children.

The effects of some life change events are less obvious to many parents. Life change events are external changes in the child's life that require the child to adjust the way he or she thinks, feels, or behaves to live happily with the change in circumstances. Some life

change events, such as the death of a pet, are also adverse events. But other life change events, because they are not adverse, do not seem stressful.

Many children happily look forward to the birth of a brother or sister. But when the child arrives, many changes occur: The family's schedule must adapt to the baby's sleeping and eating schedule, the parents do not have as much time to spend with their first child, the periodic bawling of the baby interrupts family activities, and a room the first child once used as a playroom is no longer available. These changes are minimally adverse, but they force the first child to make changes. Usually, children can handle most adverse events and stressful events with little difficulty. But when many of these events pile up on one another, they can bring on or worsen psychological problems.

It's easy to see the psychological and social side of stress. It affects how children think about themselves and changes how they interact with the social world around them. But stress also has a biological side, which has been pretty well described by neuroscientists, who view stress as a response created by nature to prepare the body for emergencies. When faced with a threatening situation, our brain's stress center automatically triggers the "fight-or-flight" response, which literally prepares us to protect ourselves by fighting a danger or by fleeing from it. When the response is triggered, many of the brain's nerve cells fire and chemical messengers called hormones are sent into the bloodstream. These messages increase heart rate, blood pressure, and blood sugar. They also increase the amount of blood sent to the muscles. This provides the muscles with the extra oxygen and sugar they might need to fight or flee the stress. The neural and chemical messages heighten our senses and reduce our sense of pain.

In the short run, the body's stress response is very useful for helping us deal with danger and stress. But when stress occurs over a long period of time, the chemical changes experienced by the body can be harmful. Sustained stress can harm the immune system, making us more susceptible to disease. It can worsen medical conditions such as high blood pressure, diabetes, and asthma. And stress can directly damage the brain, particularly areas involved in learning and memory. We do not completely understand the mechanisms through

which the biological effects of stress affect psychological disorders, but we do know that stress will worsen many conditions and may be a contributing factor to others.

You might be surprised to see viruses and infections listed in Table 3.1. Viruses definitely can cause psychological problems, but viral infection is a rare cause of psychological disorders unless there has been a widespread epidemic, as in 1917, when there was a worldwide outbreak of encephalitis, an inflammation of the brain usually caused by viral infection. Children affected by the epidemic were hyperactive, impulsive, and inattentive. They had a viral form of what today we call attention-deficit/hyperactivity disorder. Bacterial infections can also cause psychological disorders. The best studied of these is pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS). When PANDAS strikes children, it typically occurs after a strep throat infection and leads to a very quick onset of tics, obsessions, or compulsions. Chapter 9 will explain these symptoms in detail. For now, it is enough to know that tics are sudden, recurring, rapid, uncontrollable movements or vocalizations; obsessions are unpleasant; intrusive thoughts, and compulsions are repetitive behaviors. PANDAS also leads to irritability and moodiness.

We do not know why PANDAS affects some children who have strep throat but not others. But we do have a general idea of why it happens. When bacteria invade the body, the body's self-defense system (its immune system) creates antibodies to attack the invading bacteria. Sometimes the antibodies make mistakes and attack the body's own cells. For example, in response to rheumatic fever, antibodies will sometimes attack cells in the heart and joints, leading to heart disease and arthritis. In some children, antibodies that attack strep bacteria attack nerve cells in a part of the brain called the basal ganglia. It is the destruction of these nerve cells that we believe leads to the PANDAS syndrome.

In the case of viral and bacterial causes, sometimes the psychological problems go away when the virus or bacterium is treated effectively (such as with antibiotics for strep throat); other times they do not. The fact that we don't know why the psychological symptoms remain sometimes but not in others shows how much we still have to learn about the complex pathways to psychiatric problems.

Do Parents Cause Child Psychological Problems? In a Word, No

For much of the 20th century, most doctors believed that parents, particularly mothers, caused psychological problems in children. This idea stemmed from three observations.

1. Maternal influence seemed very important because children spend so much time with their mothers, especially during the crucial period of early development. We now know that many influences affect children during this period of life and that some of these influences, be they biological or psychosocial, can have a greater impact on child problems than maternal influence.
2. Doctors also had thought that bad parenting would explain why psychological problems were often seen in children from the same family. We now realize that children from the same family share genes and that these genes can make them susceptible to psychological problems.
3. Also, it seemed obvious to doctors that extreme adversity hurt the psychological development of children. For example, early studies examined children reared in orphanages who received almost no affection, attention, or interpersonal stimulation. They had no mothers and did not receive maternal care from another person. These children showed many psychological problems later in life. Doctors reasoned that if these extreme cases of poor mothering could cause problems, less extreme cases could as well. We now know that it is a mistake to generalize from severe maternal deprivation to minor mothering problems.

To justify their ideas about bad mothering, doctors came up with all sorts of theories about how mothers caused mental illness. Although these ideas seemed logical, when they were tested in clinics and laboratories, they did not stand up to the tests of the scientific method. They simply could not explain most cases of child psychological problems.

Unfortunately, these theories are dying a slow death. The idea that mothers cause their children's problems was believed for so long that it has permeated our culture, especially in the popular press, books, and movies. This leads parents to blame themselves for their child's problems, which only worsens and complicates an already difficult situation.

This does not mean, of course, that parenting is irrelevant to the well-being of children. Parenting affects the psychological health of children, but it does not explain why some children have problems and others do not. Bad parenting does hurt children, but it is not the sole cause

or even the main cause of psychological problems. If bad parenting were the main cause of psychological problems, twin studies should find that non-twin brothers tend to have the same types of problems, but they don't. They find that genetically identical brothers are much more likely to share the same types of problems than non-identical brothers. The difference between the identical and non-identical pairs is so strong that we must conclude that the environment in which the brothers are raised plays only a small role in the creation of psychological problems, and bad parenting can be only one small part of that environment.

Twin studies have also been able to separate the influence of environment shared by siblings from the influence of environment not shared. Examples of shared environment include parenting style, social class of the family, fighting between parents, and type of food served in the household. Nonshared environment refers to factors like head injuries (one brother falls out of a tree, the other does not) and exposure to different peer groups (the two brothers have different sets of friends). Remarkably, when twin studies do implicate environmental influences in psychological problems, they attribute a large role to nonshared environmental influences and a small or negligible role to shared environmental influences. Because most parental influences, such as parenting, are shared between siblings, the twin studies suggest that bad parenting is not a strong cause of childhood problems.

There are three main ways that parenting *does* matter. First is the case of extreme adversity. Physical and verbal abuse often leads to serious psychological problems. Low levels of abuse teach children not to trust others and to feel inadequate about themselves. More intense abuse leads to psychological disorders that can, without treatment, create a lifetime of misery for the abused child. Parents who abuse their children must seek help immediately, for the sake of their children and the psychological health of the whole family.

Abuse is perhaps the worst example of extreme adversity, but homes that are chaotic and rife with conflict can be harmful too. In an atmosphere of constant arguing, inconsistent or nonexistent rules, unpredictable behavior, and unreliable nurturing, children rarely thrive, psychologically or physically.

If your child has one of the psychological disorders described in the next chapters, parenting can affect the severity of the problem and its response to treatment, even if parenting did not initially cause the problem. For example, some children who are shy eventually develop extreme and unreasonable fears or experience episodes of incapacitating panic. Parenting does not cause these problems, but as we shall see in a later chapter, the parents of fearful or panicky children can adjust

their parenting to help their child learn to live a less fearful life. So even if parenting does not cause a problem, special parenting approaches can help alleviate a problem once it occurs.

Last but not least, good parenting is essential, not only for reducing the adverse impacts of psychological problems, but also for fostering psychological health, teaching values, and promoting self-esteem. As parents we are constantly dodging bullets, avoiding the mistakes and mishaps that foul up family life and knock children off the course of normal, healthy development. But effective parenting is more than just avoiding problems. Effective parents create a stable and loving home regulated by clear, reasonable rules. Effective parents pass on the personal, religious, and philosophical values that help children make sense of their world and provide them with guides for their behavior. Effective parents encourage achievement but do not set unreasonable goals. Effective parents help children feel good about themselves.

HOW LIKELY IS YOUR CHILD TO HAVE A DISORDER?

The causes of psychological problems and disorders are summarized in the diagram on the following page, which scientists call the vulnerability–stress model. It shows how various influences can combine to cause psychological disorders in children. The more vulnerability (genetic predisposition) your child has, and the more environmental stresses the child is subject to, the more likely he or she is to end up with a psychological disorder.

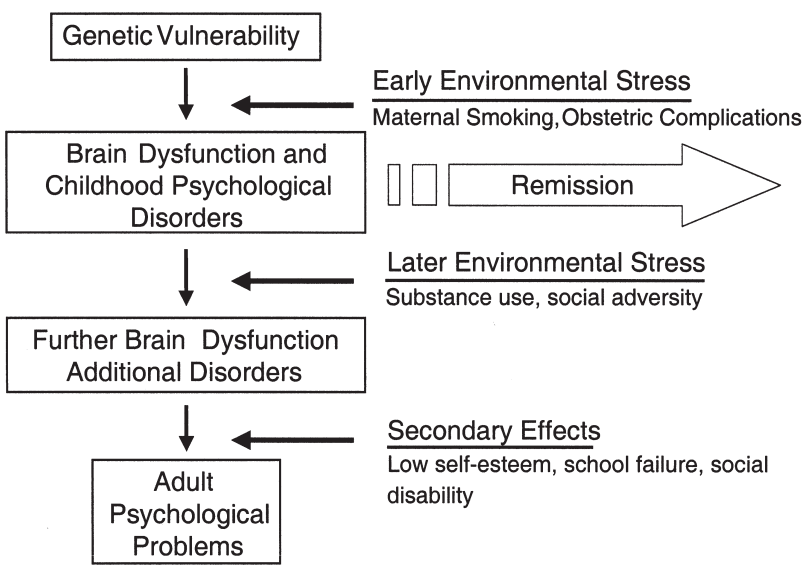
Read the model from the top down. It starts at the beginning of life, when all we have is the genes we inherit from our parents. There are probably tens of thousands of genes involved in building the brain and operating it though life. For each of these genes we can inherit a protective variant, which protects us from psychological problems, a neutral variant, which has no effect, or a harmful variant, which when combined with other bad variants predisposes us to problems. Depending on the pattern of genes we inherit, we will be more or less vulnerable to psychological problems and disorders. At one extreme, some people will inherit so many of the protective variants that they will be very unlikely to develop problems, even when faced with severe and persistent stress. At the other extreme, some people will have so many of the harmful variants that they are very

likely to have problems, even in low stress environments. Most of us fall somewhere in between these two extremes.

The next step in the diagram shows that early environmental events combine with our genetic vulnerability to create brain dysfunction and one or more psychological disorders. By "early" I mean during the mother's pregnancy or the child's preteen years. Problems may emerge at any time during the preteen years, and these problems might go into remission (they mostly go away) or they may persist into adolescence. As the model suggests, persistence is aided by later environmental stresses, which might lead to more brain problems and additional disorders.

The longer the child has the disorder the more he or she will be subject to secondary effects, which are stresses caused by having the disorder, such as having a bad self-image, doing poorly in school, or not having many friends. These secondary effects cause more stress, which can worsen the adolescent's problems and make it more likely they will persist into adulthood.

The main point conveyed by the vulnerability–stress model is that the causes of psychological problems are extremely complex. They are not completely determined by either the child's genes or



the environment. It is the complex interplay among many genes and many environmental events that leads some children to have psychological problems and others not.

The vulnerability–stress model and the details you've learned in this chapter should help you understand the type of professional help your child may need to overcome his or her psychological problems. Now that you understand that most disorders have a biological foundation in genetics and the brain, it should be easier for you to understand why your doctor might suggest that your child needs a medicine. Although many psychological problems are helped with biological treatments, however, be aware that the fact that these conditions have a genetic basis and a biological manifestation in the brain does not mean that *only* biological treatments will be effective. A good example is learning disabilities. We know that learning problems are strongly influenced by genes and that children with learning disabilities show brain abnormalities. Yet, despite this clear biological basis, there is no biological therapy for learning problems. Instead, special teaching methods are used to help these children learn to read. Again, we are managing the symptoms, in some cases very effectively, but we are not curing the disease. Someday, if we learn how and when to interrupt the neural development that produces symptoms of learning disabilities, we will be able to eradicate the disability. Understanding that disorders have widespread and complex effects on your child's psychological and social life will also help you understand why doctors ask so many questions and why the treatment program they choose might include psychological therapies.

If you keep the vulnerability–stress model in mind as you read the rest of this book, it will help you better understand how doctors think about the diagnosis and treatment of psychological problems. Knowing that information will help you to help your child. In the chapters that come, you will learn that doctors have categorized psychological problems into several groupings, or diagnoses, based on the thoughts, behaviors, and feelings of children. They will try to find the best diagnosis for your child because that will help them understand your child's biological vulnerabilities, which, in turn, will help them decide on the best treatment. They will not be able to point to an X-ray and say, "Here's your child's problem," but they will be able

to use a large research literature about similar children to get a pretty good idea of the nature of your child's vulnerabilities.

The doctor will also try to figure out the unique mix of vulnerability and stress that has combined to create your child's problem. By identifying stressors, the doctor can help you lessen some of them. Because you now have a good idea of what doctors mean by stress, it should be easier for you to see if and how stress is affecting your child. By helping you understand the mix of vulnerability and stress in your child's life, the doctor will also be able to give you ideas about how you might possibly prevent the worsening of problems or the emergence of new ones.

Part II

DIAGNOSES AND DISORDERS

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Chapter 4

Disruptive Behavior

If you have a disruptive child, you undoubtedly knew it before you opened this book. Now that you've read Chapters 1 and 2, you may suspect your child's disruptive behavior is caused by a diagnosable disorder. But which one? Disruptive behavior tends to take center stage, shoving the signs of any other problems a child may have into the wings. That doesn't mean, however, that it is your child's core problem. Some kids who exhibit disruptive behavior actually have mood disorders, such as bipolar disorder. Disorders of unruly behavior also take many different forms in different kids. The relentless defiance you see in your son may not be oppositional defiant disorder (ODD) but a child's response to expectations from parents and teachers that attention-deficit/hyperactivity disorder (ADHD) won't let him meet. To complicate matters, children who have any of the four main types of disorders characterized by disruptive behavior—ADHD, ODD, conduct disorder (CD), or alcohol or drug use disorders—often have other disorders as well.

Disorders of disruptive behavior are often characterized as a progressive group, with ADHD leading to ODD and ODD leading to CD when the child remains untreated. While it's true that within this group ADHD and ODD are likely to appear earlier in life and CD later—ADHD, for instance, occurs before adolescence—not all kids who start out diagnosed with ADHD end up with the other disruptive behavior disorders. About half of all children diagnosed with ADHD ultimately end up with ODD, and about a third end up with CD. As to alcohol and drug abuse, kids who have the excessive

impulsivity and lack of inhibition typical of ADHD are more disposed to errors in judgment like saying yes to an offer of alcohol or drugs than kids who don't have ADHD. Despite widespread myths to the contrary, the stimulant medications so effective in treating ADHD do not lead kids to abuse street drugs. In fact, medication exerts a protective effect on these kids, returning the teen with ADHD to approximately the same risk level for drug abuse that an adolescent without ADHD has.

Because disruptive behavior can damage a child's home life, school achievement, and ability to fit into a society governed by many laws and rules, it's paramount that a child with any of these disorders get appropriate treatment as soon as possible. I don't expect you to make your own diagnosis, but I hope this chapter will help you judge whether your child should be evaluated for one of these disorders.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

What Is Attention-Deficit/Hyperactivity Disorder?

Of all childhood psychiatric disorders, attention-deficit/hyperactivity disorder (ADHD) may be both the most well known and the most widely misunderstood. About 1 in 10 children develop ADHD, making it one of the most common childhood psychiatric disorders worldwide, and almost everyone knows someone who has been diagnosed with it. Mental health scientists know more about this disorder than about any other psychological problem that affects children, yet we still have much to learn. Scientists are still trying to determine, for example, exactly what causes the disorder and what the core deficit is. Reams of evidence document the effectiveness of medicines like Ritalin and Adderall in treating ADHD, and brain imaging studies have identified the part of the brain where some of these medicines act, but we still do not know precisely how and why they are so helpful for many children.

These gaps in our knowledge have led to disagreement about many aspects of ADHD among mental health professionals and others. To make matters worse for parents trying to understand this widespread disorder, the press often misrepresents or misinterprets

even the facts that are the most thoroughly substantiated. A brief discussion of the myths and misinformation surrounding ADHD appears toward the end of this section. What's important is that you question whatever you hear, determine the reliability of the source, and try to figure out the validity of any information that you encounter. In the following pages I'll give you up-to-date facts, as of the writing of this book, based on reliable research and my clinical and research experience.

FAST FACTS about Attention-Deficit/Hyperactivity Disorder

1. A disorder of inattention, hyperactivity and impulsivity
2. Diagnosed in 5–10% of children
3. More common in boys than girls
4. Starts in early childhood, before age 7
5. Often seen with oppositional, conduct, mood, anxiety, and learning disorders

One thing that has become clear over the years is that ADHD can take different forms—so different, in fact, that it can be hard to believe that two children diagnosed with it really do have the same disorder. Jerry, the live wire described in Chapter 1, is clearly hyperactive, while Gloria, also described in Chapter 1, seems mainly spacy and distractible. They both have ADHD, and some of the consequences of their disorder are the same (poor academic performance, for example), but Jerry has been diagnosed with ADHD, combined subtype, while Gloria has ADHD, inattentive subtype.

Seven-year-old Frank is a quiet little boy who rarely disrupts others. But his parents need to plow a path through the toys cluttering his bedroom, his desk at school is in disarray, and he frequently loses homework assignments, baseball cards, and more. At school his attention wanders out windows and into his imagination. Because he is careless, he makes many errors on tests and worksheets. Both his parents and teachers say that he doesn't seem to hear when they are speaking to him.

When the teacher told Frank's parents he might have ADHD, they disagreed. After all, they knew two children with ADHD. One was a neighbor and the other Frank's cousin. Both were rambunctious little devils who were constantly intruding on others, climbing on furniture, interrupting their teachers, and, in the process, causing a good deal of trouble. If these boys had ADHD, how could Frank? The answer is that Frank has inattentive ADHD and the other boys have hyperactive–impulsive ADHD.

These subtypes, and even the term *attention-deficit/hyperactivity disorder*, have been used by diagnosticians only since the 1990s. The definition of the disorder and even its name have changed markedly over the past three decades. In the 1960s and 1970s, these children were called *hyperactive* because the experts believed that excessive physical and verbal activity was the primary sign of the disorder. Then, in the 1980s, after scrutinizing decades of research, the experts renamed the disorder *attention deficit disorder (ADD)*. This revision emphasized attention problems as a primary sign of the disorder, but it also recognized the importance of hyperactivity by including a variant of ADD called *ADD with hyperactivity, or ADDH*. The term *ADHD* and its three subtypes—the *inattentive subtype*, the *hyperactive–impulsive subtype*, and the *combined subtype*—were defined in 1994, in recognition of the varying manifestations of the disorder and the need for highly structured diagnostic methods. As a consequence, kids who are mainly inattentive and not hyperactive and disruptive are not overlooked (and untreated); nor are the typically very young children who are hyperactive–impulsive without being inattentive. There is, however, still a lot of debate over whether the subtypes are delineated accurately, so don't be surprised if further refinement of the ADHD diagnosis occurs in the future. Whatever subtype your child is diagnosed with, he is still likely to be prescribed medication, because the evidence of its effectiveness in all types of ADHD is so strong.

The issue of names aside, ADHD is characterized by three types of problem behavior: inattention, hyperactivity, and impul sivity. Table 4.1 lists the specific behaviors used to diagnose ADHD according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV).

TABLE 4.1. Behaviors Leading to the DSM-IV Diagnosis of ADHD

Inattentive symptoms	
Does not attend to details or makes careless mistakes	Has difficulty sustaining attention
Does not listen when spoken to	Does not follow through on instructions or fails to finish tasks
Often has difficulty organizing activities	Often avoids or dislikes tasks requiring sustained mental effort
Often loses things	Often is easily distracted
Often is forgetful	
Hyperactive symptoms	
Often fidgets or squirms in chair	Often leaves seat without permission
Often runs around or climbs excessively	Often cannot play quietly
Often is "on the go" or acts as if "driven by a motor"	Often talks excessively
Impulsive symptoms	
Often blurts out answers	Often has difficulty waiting turn
Often interrupts or intrudes on others	

Note. Some symptoms must have caused problems before age 7. Problems from symptoms must occur in at least two settings (e.g., home and school). The symptoms cannot be accounted for by another disorder. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

Inattention

What the inattentive symptoms listed in the Table 4.1 add up to is marked difficulty paying attention to whatever the child should be focusing on, be it schoolwork, a TV show, or instructions from a parent. Poor attention leads to daydreaming, distractibility, and difficulties sustaining effort on a single task for a prolonged period of time. As their attention wanders from one stimulus to the next, kids with ADHD often leave parents and teachers with the impression that they are disobeying instructions.

It's easy to lose patience with an inattentive child. Most of us understand that paying attention can be difficult, especially when a more interesting alternative is there to distract us, but we believe that all it takes to stick to the task at hand is nose-to-the-grindstone effort. What may be hard for parents of children with ADHD—and other adults who supervise these kids—to grasp is that children with ADHD simply don't have the same ability to pay attention that the rest of us have.

Attention is one of the most important functions of the human brain. It's the brain's gatekeeper. When attention fails, the child's daily functioning also fails, in numerous ways that are hard to imagine. The brain's gatekeeper checks all incoming information to see if it is relevant to the task at hand. Without the full power of that gatekeeper, kids with ADHD have a hard time shutting out the background "noise" of life and sticking to what they need to accomplish. Most fifth graders, for example, can sit at their desk and work on a math worksheet for 20 minutes. Sara cannot. Her gatekeeper does a poor job of separating relevant and irrelevant information. It lets the roar of a truck take center stage, leading Sara to wonder where it is going and what it is carrying. It focuses the child's eyes on a drawing tacked to the bulletin board, prompting her to doodle a copy on her paper. It floods Sara's brain with the enticing fragrance of peanut butter and jelly wafting up from a lunch sack. Instead of working, she wonders how long it will be till lunch and whether the lunch sack contains cookies or cakes, soda or juice. Sara will get a failing grade on the worksheet, not because she is stupid, not because she isn't trying, not because she doesn't know her math, but because the gatekeeper of attention has not allowed her to focus her brain power on the task at hand. Sara has ADHD. And it isn't just Sara's schoolwork that suffers because of her inability to pay attention. When she's playing with friends she sometimes seems to ignore them because her attention has strayed. These lapses of attention annoy other children and have made it more and more difficult for Sara to maintain friendships.

Hyperactivity

The meaning of hyperactivity is straightforward. Kids with ADHD are much more active than most children. They run around the

house, climb on furniture, fidget in chairs, rustle school papers, tap their pencil on their desk and, at times, talk incessantly. Put simply, they are "always on the go," giving their parents the impression that they have an extra reserve of energy that drives them like a motor into excessive activity. Hyperactivity often subsides in adolescence and adulthood, but it can still be evident. The difference is in the way the teen or adult has adapted to the restlessness of the disorder. Whereas the 5-year-old may find it virtually impossible to sit at a desk, the 15-year-old will generally stay at his or her desk but may ask permission for trips to the bathroom or find other reasons to leave the classroom early. The hyperactive teen or adult is frequently restless and shifts from one activity to another. A day at the beach may mean not tanning on a towel but playing volleyball and surfing all day. In kids with ADHD as well as in kids without it, the brain matures with time, and even kids with the challenges of ADHD improve their self-control and adapt to society's expectations as they grow.

Impulsivity

Children with ADHD frequently act without thinking. Impulsivity makes them accident-prone, creates problems with peers, and disrupts classrooms as they blurt out answers, interrupt others, or shift from schoolwork to inappropriate activities. Impulsive children cannot stop their first reactions to an event. This can become dangerous if, for example, they chase a ball across a street without stopping to check for traffic. Impulsivity also causes problems with peers because it makes it hard for children with ADHD to wait their turn on the lunch line or at the water fountain.

Joaquin is rarely invited to birthday parties because all the parents in the neighborhood consider him unforgivably rude. He talks over adults, grabs the first piece of cake, and blows out the birthday child's candles, insists on "helping" with the opening of the presents, shoves in front for every game, and always rushes out the door after grabbing his goodie bag without so much as a look backward, much less a "thanks for having me." It's not that Joaquin's parents haven't taught him any manners. It's just that no one realizes yet that this 5-year-old has ADHD, and he can't restrain his impulses to do whatever catches his fancy at the moment.

Diagnostic Challenges

Which subtype of ADHD a child is diagnosed with depends on the mix of the three types of behavior that the child shows. There is no denying that the existence of these subtypes can make diagnosing ADHD more complicated than diagnosing the other disruptive behavior disorders. To be diagnosed with the inattentive subtype of ADHD, the child must show six or more of the inattentive symptoms for at least 6 months. To be diagnosed with the hyperactive–impulsive subtype of ADHD, the child must show six or more of the hyperactive or impulsive symptoms for at least 6 months. If the child can be diagnosed as both inattentive ADHD and hyperactive–impulsive ADHD, he is considered to have the combined subtype of ADHD.

Another complicating factor is the possibility that the ADHD symptoms are caused by a different condition. Shirley's teacher rolls her eyes every time she has to try to lure the child's attention back to the blackboard or a test or a group project. She sighs in exasperation when she has to tell Shirley twice more than the other kids to get in line for lunch. She's seen a lot of cases of ADHD and has suggested to Shirley's parents that they might want to have her evaluated for the inattentive type of the disorder. Fortunately, Shirley's pediatrician did extensive hearing and vision tests first and found out that her chronic ear infections over most of her childhood have impaired Shirley's hearing more than anyone ever guessed before. Inattention can also be caused by seizures, and, in rare cases, even generalized resistance to thyroid hormone.

David's pediatrician wasn't sure what was wrong with him, and so he referred David's parents to a psychologist for a more extensive evaluation. David was having trouble paying attention in school, just like Shirley, and he also fidgeted and fussed constantly. ADHD seemed to be a likely culprit. But further exploration revealed that David was inattentive or restless only during bursts of nervousness. When this nervousness was investigated, the psychologists diagnosed David with generalized anxiety disorder (GAD; see Chapter 6) rather than ADHD. Antianxiety medication (see Chapter 11) calmed David down and allowed him to concentrate in school and elsewhere.

David illustrates why one diagnostic criterion is that the ADHD symptoms must not be better accounted for by another condition.

However, David's doctor had to take into account the research showing that many children with ADHD are nervous and moody. This means you and the clinician evaluating your child should be very cautious about interpreting ADHD symptoms as *caused* by a mood problem rather than ADHD. It's entirely possible that your child needs treatment for ADHD in addition to these other conditions. Not diagnosing ADHD would be reasonable only if the ADHD symptoms occurred strictly during discrete bouts of nerves or mood disruption, as they did with David.

During an evaluation, a practitioner will try to discern not only whether your child has the minimum number of symptoms from Table 4.1 but also how long he or she has had them and how pervasive they are. The *Diagnostic and Statustical Manual of Mental Disorders*, fourth edition (DSM-IV) states that some ADHD symptoms must have caused problems before age 7. So, for a teenager who meets all criteria for ADHD but did not have symptoms prior to age 7, the practitioner will look for another explanation. Dana, who had been exhibiting the symptoms of inattentive ADHD since age 13, was found instead to be suffering from dysthymia, a form of depression. Steve couldn't focus at school and never seemed to hear his parents talking to him, but the problems had just appeared a few months earlier, and eventually Steve was found to be using marijuana.

Problems from ADHD behaviors also must occur in at least two settings. For children this is usually at home and in school. For teens, one of the settings can also be work. If the ADHD behaviors are present in only one setting, a mental health professional might explore the possibility that there is something unusual about the setting that elicits the ADHD behaviors. Jessie, for example, was reported to be overactive and impulsive at home, though her teachers never noted such a problem. It turned out that her parents, quiet people inclined to be somewhat sedentary, felt that Jessie's behavior was extreme when compared to their own and when seen in the context of their tranquil home life, but Jessie's behavior was well within the normal range and she did not have ADHD. Tyrell, according to his teachers, was distractible, impulsive, and disruptive. But an evaluation showed that he did not have ADHD. His behavior was normal at home, and his behavior at school was found to be the result of a learning problem and the frustration it caused Tyrell.

What Does the Future Hold for Children with ADHD?

Many studies have followed children with ADHD from childhood through adolescence and into adulthood. This work shows that, in their teens, hyperactivity and impulsivity will diminish, but the majority of children will still have enough signs of the disorder to qualify for the diagnosis. They may seem much better, but most will still have a lot of the inattentive symptoms and disorganization, in addition to some impulsivity. As a result, the teen with ADHD is at high risk for low self-esteem, difficulties with schoolwork, poor peer relationships, conflict with parents, delinquency, smoking, and substance abuse. Although all teens with ADHD end up with some of these problems, those who have had a childhood history of conduct disorder (described later) are at greatest risk for serious adverse outcomes, including criminality and drug abuse in adulthood. In fact, one study found that one in four adult prisoners had ADHD.

Long-term studies of children with ADHD show that as many as two thirds of them have impairing ADHD symptoms as adults. These symptoms make their lives difficult in many ways. If they attend college, they earn lower grades than their peers and are more likely to be placed on academic probation. When they finish school, they have problems at work and frequently quit in frustration or are fired for poor performance. As a result, their social, occupational, and financial achievements fall short of their capabilities.

The inattention and impulsivity of adults with ADHD leads to poor driving skills. Compared with other adults, they are much more likely to have speeding citations, suspended licenses, and crashes. Adults with ADHD also have difficulties with long-term relationships, as evidenced by increased rates of divorce and remarriage compared with other adults.

Of course not all children with ADHD will have these problems as adults. Some will have very good outcomes (about 15% will no longer have ADHD); most will show some signs of the disorder; and a few will have seriously impairing symptoms for much of their lives. For ADHD and other conditions, you will need to discuss your child's specific case with the doctor to get a better idea of what the future holds. Fortunately, treatment does make a difference.

A Roadmap to Treatment: ADHD*

Medicines

1. Stimulants
   - Methylphenidate, dextroamphetamine, mixed amphetamine salts
   - Long-acting preparations of the above require only one dose in the morning:
     Methylphenidate: Concerta, Ritalin LA, Metadate, Focalin
     Mixed amphetamine salts: Adderall XR
2. Atomoxetine: Strattera
3. Others
   - Desipramine, nortriptyline, imipramine (less frequently used due to cardiac side effects)
   - Clonidine, guanfacine (especially for children with tics, aggression, or prominent hyperactivity-impulsivity)
   - Bupropion

Psychological Treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Behavior treatment: when medications do not produce full control of the disorder, behavioral treatment is warranted:
   - Parent management training
   - Accommodations in the classroom
   - Social skills training may help some children who have problems socializing

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

ADHD in the Media: Profit over Principle

If you read the papers or watch the TV news, you have probably heard claims that ADHD is overdiagnosed, that under the guise of this diagnosis normally rambunctious children are being drugged into submission, that there may be no such thing as ADHD in the first place. Unfortunately, the news media have been full of error-ridden and even inflammatory reports about ADHD. Just as unfortunately, ADHD is sometimes misdiagnosed, usually because the evaluation hasn't been as thorough as it should be, consisting possibly of a simple questionnaire and a brief discussion with the parents. Practitioners rushed by an increasingly cost-conscious health care system may not make sure the symptoms occur in at least two settings (school and home) or that the child is actually impaired. Such lapses notwithstanding and contrary to media reports, studies have shown that ADHD is more likely *under*-diagnosed than overdiagnosed. One recent multisite study sponsored by the National Institute of Mental Health found that as many as half of the kids who qualified for a diagnosis of ADHD across five major U.S. regions had either not been diagnosed or were not being treated appropriately.

Because ADHD is common and disabling, it has become a popular—and profitable—topic for human interest news and the talk show circuit. ADHD is an ideal media target. Because it affects 5–10% of children, many concerned parents will tune in. Because it is usually treated with stimulant medications (which are chemically similar to drugs of abuse like amphetamines), it is easy to raise the red flag of fear and claim that doctors are "drugging" America's children. If you have seen any of these media reports, please note that these are usually simplistic, frequently misleading, and sometimes inaccurate.

For example, in 1999 CNN reported that "a defining, biological test may finally be possible for attention deficit hyperactivity disorder, a poorly understood condition that has caused millions of American children to be placed on mind-altering drugs. . . . Mind-affecting drugs such as Ritalin are the most common treatment, but some doctors and parents worry about their long-term effects, which have never been studied."

The facts are these:

1. There is no biological test for ADHD.
2. As stated earlier, although we have much to learn about the disorder, we know more about ADHD than virtually any other psychiatric disorder of children.
3. The term *mind-altering* is inflammatory, calling up images of drugs of abuse, like the LSD of the 1960s and 1970s. In fact, any drug used to treat psychiatric disorders alters the workings of the mind in some way, but *therapeutically,* the way antidepressants can prevent the trag-

edy of teenage suicide. One wonders why the report used that term instead of the more accurate phrase "Drugs such as Ritalin, which improve attention, impulsivity, and hyperactivity. . . . "

4. It's impossible to conduct long-term double-blind controlled studies of Ritalin in children (see Chapter 11 for more information on such studies), but that doesn't mean that long-term effects have not been observed and recorded. Because this medicine has been used for decades, we know as much or more about its effects than most other medicines prescribed by psychiatrists, and there is no evidence of long-term damage of any kind.

Because teens and adults with ADHD are at risk for drug abuse, media reports have implied that their drug use was caused by their prior use of Ritalin or similar drugs for treatment. This is simply not true. First of all, stimulants like Ritalin do not have the same effect on kids with ADHD as the amphetamines ("speed") that are popular street drugs. When taken in normal therapeutic doses, these medicines do not provide the dramatic high craved by drug abusers. Drug abusers use high doses of stimulants and take them by snorting, injection, or any other method that gets the drug to the brain very quickly. In contrast, the stimulant medicines for ADHD are given in much smaller doses and enter the brain slowly. Research shows, in fact, that rather than causing drug abuse, stimulant medicine protects children with ADHD from drug abuse. To address this issue, my colleagues and I at Harvard University and Massachusetts General Hospital reviewed seven studies that examined the effects of medications for ADHD on later substance abuse. We found that use of these medications cut the risk for substance abuse in half, down to the level of children who did not have ADHD. This finding makes intuitive sense. These medicines reduce the symptoms of the disorder that lead to illicit drug use. For example, an impulsive teenager with ADHD who acts without thinking is much more likely to use drugs than one whose symptoms are controlled by medical drug treatment.

Why do the media mislead the public about the effects of stimulant treatment despite decades of clinical use and research that show these medicines to have minimal adverse effects? The answer may well be that sensation and controversy rivet the attention of the American public, improve ratings, and accelerate the sales of popular books. Many parents are understandably concerned about giving psychiatric medicine to their children over a long period of time, a concern that is heightened by current trends favoring "natural" over "chemical" remedies. Clearly, when we consider any medical treatment we must weigh its risks against its benefits. But to make that decision you need information from experts, not from the news media.

OPPOSITIONAL DEFIANT DISORDER (ODD)

What Is Oppositional Defiant Disorder?

The defiant child is psychology's Bart Simpson. He finds it difficult to live within the rules of society and the family. Defiant children break rules, rebel against parents, and aggravate teachers with their persistently disobedient, defiant, negative, and hostile behavior.

FAST FACTS about Oppositional Defiant Disorder

1. Describes stubborn, argumentative, disobedient children
2. Diagnosed in 3–10% of children
3. More common in boys than girls
4. Can start in childhood or adolescence
5. Often seen with ADHD. May lead to conduct disorder.

Despite these irritating behaviors, the defiant child does not seriously violate the basic rights of others. Oppositionality is not defined by rule breaking, and while the child with ODD can be argumentative, aggravating, noncompliant, angry, annoying, or irritating, he or she is not violent or cruel. Defiant children will swear at adults, be late for class, argue with their teachers, annoy other children, and refuse to do chores, but they usually do not break the law or physically attack others.

Table 4.2 describes the specific behaviors that would lead a professional to diagnose ODD. As you can see from the table, defiant children are hostile; they have angry outbursts and temper tantrums in response to specific events such as a parent telling them to do chores. In addition to these periodic outbursts, they are often in a bad mood: angry, resentful, or annoyed. Every child behaves like this sometimes, but for children who have ODD it is part of every day and almost every interaction.

Defiant children are disruptive in every arena of their lives. They make noise during tests at school, leave their chores for other

family members to complete, exceed their quota of television time, have bad table manners, and so forth. At times, their defiance seems spiteful or vindictive. What this means is that they seem to disobey on purpose to irritate parents, siblings, peers, or teachers. Although this pattern of persistent anger and petty rule breaking does not come close to dangerous or illegal acts, the defiant child creates a tense atmosphere at home and can be very disruptive in the classroom.

The points made in the note to Table 4.2 deserve additional comment because they highlight two reasons why psychiatric diagnoses should be made only by qualified professionals. Diagnosis is not a simple matter of counting problem behaviors. The diagnostician must determine if the behavior is actually present. This is not as simple as it might seem. For example, consider one behavior of defiant children, "Often argues with adults." Most parents will acknowledge that their child has, at times, argued with adults. It is easy to recognize that arguments have occurred but difficult to know if they occur "often." To help diagnosticians, the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) defines "often" as more than one would expect given the child's age (which is easy to gauge) and developmental level (which is not so easy to gauge).

TABLE 4.2. Behaviors Leading to the DSM-IV Diagnosis of Oppositional Defiant Disorder

Often loses temper	Often argues with adults
Often defies adults or refuses to comply with rules	Often deliberately annoys others
Often blames others for his or her problems	Often is easily annoyed
Often is angry or resentful	Often is spiteful or vindictive

Note. The child must have shown at least four oppositional behaviors in the past 6 months. The behavior must be more frequent than is expected given the child's current age and developmental level and must cause problems with friends or family or at work. The behavior must not be limited to episodes of psychotic or mood disorders. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

Most parents cannot easily figure out if their child meets these tests for "often" because they have not been exposed to a large number of children of the same age and because they have not been trained to understand what is meant by developmental level (although by now you should have a better understanding of this latter term from your reading of Chapter 1). In contrast, the training of diagnosticians exposes them to many children of different ages and developmental levels. When you tell an experienced diagnostician that your 8-year-old child argues with adults about three times each week, the diagnostician can, more easily than you, judge whether that is unusual for 8-year-old children at the same stage of development as your child. (Teachers, too, are exposed to lots of kids, and they can probably advise you on whether your child's defiance seems normal for his or her age, though they are not qualified to make a diagnosis.)

The second reason that only a professional should make a diagnosis is that the criteria for diagnosing many disorders, such as ODD, include an "exclusion criterion." A child should not be diagnosed with ODD if the defiant behaviors occur only during episodes of psychotic or mood disorders. Parents are not qualified to identify episodes of psychotic or mood disorders—or any other disorder for that matter—so they have no way of knowing whether defiant behavior is actually part of some other problem rather than ODD.

Most parents of defiant children are wracked with guilt and self-blame—a condition that's hard to avoid when other adults are constantly looking askance at their fruitless efforts to control their child's disruptive behavior. As with ADHD, there is no biological test for ODD. Unlike for ADHD, we don't know much about abnormalities in neurochemicals or brain structure in ODD. What we speculate is that ODD is caused by a combination of biology and environment, like all other psychiatric disorders. In the case of ODD, biology may translate mostly as temperament, and environment may mean mainly stressors plus problematic parent–child interactions. When a volatile temperament meets a chaotic home life and inconsistent parenting that centers on escalating punishment, ODD often emerges from the smoke. As mentioned at the beginning of this chapter, about half of kids with ADHD end up with ODD, but we have no data to explain how the two may be connected.

What Does the Future Hold for Defiant Children?

To understand what the future holds for defiant children you first must understand that there are at least three types of childhood defiance. One type occurs in children with mood disorders. For these children, defiant behavior arises from their frequently irritable mood. You will learn about these children in Chapter 5.

A second type of defiant child has a relatively mild case of ODD that is not likely to worsen to serious antisocial behavior. These children are not at high risk for complications such as criminal activity or drug and alcohol abuse. Nevertheless, these children will cause persistent problems for their parents, teachers, and peers unless the problem is addressed through some form of treatment.

A third type of defiant child has a condition that will eventually progress to serious antisocial behavior. Research shows that nearly all seriously antisocial children had been defiant children for several years before they showed signs of conduct disorder (CD). So for these children, ODD is a signal that warns of worse behavior to come.

Unfortunately, the only way to determine whether successful treatment of ODD would prevent CD from developing would be to

A Roadmap to Treatment: ODD*

Medicines

There is no specific pharmacological treatment for ODD. Stimulants may reduce aggression. Treatment for any co-occurring mood disorder may help.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Parent management training
3. Collaborative problem solving

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

do a long-term study of treated and untreated children, and it is unethical to deny treatment to some children in the name of research. There are, however, other clues that can predict which defiant children will worsen and be at risk for criminality and dangerous behavior. One is the presence of serious antisocial behavior in siblings or parents. Another is abuse of alcohol or drugs by family members. Also, defiant children who show signs of the disorder at a very early age or have severe and frequent symptoms are more likely to progress to more serious problems. When defiant children worsen, they are diagnosed with CD, the subject of the next section.

CONDUCT DISORDER (CD)

What Is Conduct Disorder?

If you are familiar with the term *juvenile delinquent,* you have a general idea of how children with conduct disorder behave. These children are the schoolyard bullies, the shoplifters, the vandals, the runaways. The diagnosis of CD is not intended to explain why these children engage in antisocial behavior or to excuse the behavior. The diagnosis is intended to define the level of severity that the child's antisocial behavior has reached. For children to receive this diagnosis, they must show a persistent pattern of antisocial behavior that ignores the rights of others and breaks the rules of society.

Life is not easy for the parents of a child with CD. If your child has this disorder, he or she may seem to lack the sense of right and wrong that you have tried so hard to teach. Frank and Glenda became concerned about Jeffrey when, at the age of 7, they were disturbed by the sadistic glee he derived from torturing frogs he had captured from the neighbor's pond. He had always been a physical, horsing-around child, which had amused Frank when Jeff was 3. But Frank's amusement soured when the rough-and-tumble antics of Jeff's early childhood grew into fistfights, vandalism, theft, and constant rule breaking at home and school. Glenda thought something seemed wrong when spare change periodically disappeared from the kitchen counter. Both she and Frank were convinced Jeff was out of control when the police caught him, the day after his 9th birthday, vandalizing school property with a group of teenagers known to be troublemakers in the community.

Like most thoughtful and caring parents, Glenda and Frank worked hard to control Frank's behavior. They changed their work schedules so they had more time to be with him at home. This, they thought, would allow them to supervise his behavior and discipline him more effectively. They read books about parenting, sought advice from friends, and worked closely with Jeff's teachers. But thoughtful discipline failed. The rewards and punishments that motivate normal children had little effect on Jeff's behavior. Thinking they were complete failures as parents, their frustration and anger about Jeff became complicated with a pervasive sorrow and hopelessness about their own abilities as parents.

FAST FACTS about Conduct Disorder

1. Describes children who violate societal rules or rights of others
2. Diagnosed in 2–4% of children
3. More common in boys than girls
4. Can start in childhood or adolescence
5. Often seen with conduct, mood, anxiety, and learning disorders

Many parents like Frank and Glenda end up blaming themselves for their child's conduct disorder. This extreme behavior creates serious problems for parents, educators, and—ultimately—the criminal justice system, and it's hard for many parents to avoid feeling guilty for the damage their child does. Children with CD are not, however, simply bad boys and girls. They are not necessarily undisciplined or "from a bad home." They have a psychiatric illness whose main symptom is antisocial behavior that is harmful to others or destructive to property. Examples include stealing, cheating, bullying, lying, running away from home, skipping school, destroying property, being physically cruel to animals, getting into fistfights, setting fires, using weapons in fights, and forcing sexual activity on others.

The problem is that, as in Jeffrey's case, conduct disorder often starts out looking like normal rambunctiousness. For that reason parents may not address it right away, and by the time they realize their efforts to control their child are ineffective the situation can feel

pretty hopeless. Although CD is not defined by a single delinquent act, you should definitely be concerned if your child breaks the law once—children with CD started out as kids who broke the law just once.

A child will be diagnosed with conduct disorder according to DSM-IV criteria when he or she shows a persistent pattern of behavior that violates the rules of society or harms others. The kid who starts a fistfight every now and then may need to learn self-control and appropriate social behavior, but unless he or she frequently shows other antisocial behaviors as well, he or she will not receive the diagnosis of CD. Only the behaviors listed in Table 4.3 count toward a diagnosis of CD, and these behaviors must lead to what professionals call "clinically significant impairments in social, academic, or occupational functioning." In other words, the child must be having problems with friends or family or must be doing poorly in school or (for teenagers) at work.

I offer these criteria as a rough guide to give you a general idea of what this diagnosis is and whether or not it may apply to your child, not as a suggestion that you should try to diagnose your child on your own. All of the diagnoses described in this chapter can be made only by a qualified mental health professional. One important reason for this is especially relevant to CD. Simply put, you may not know all there is to know about your child, which puts you at a disadvantage in making a diagnosis. A skilled professional may be able to find out about the illegal acts of a child with CD through an interview, whereas the child's parents may not know about them unless the child has been caught in the act. And as with ODD, only a professional can determine what constitutes "often" for the behaviors characteristic of CD.

Parents' judgment about frequency and severity depends very much on how their subculture has shaped their perspective. It also may depend on the peers with whom they compare their own child. You could, for example, mistakenly decide that your child must not be "that bad" because his friends all behave the same way. But kids who are on a path toward CD usually start hanging around with other children with the same behavior problems at a very early age, so what you are seeing may be a very skewed group of kids that are not representative of the norm.

TABLE 4.3. Behaviors Leading to the DSM-IV Diagnosis of Conduct Disorder

Often threatens others	Often starts physical fights
Has used a weapon in a fight	Physically cruel to people
Physically cruel to animals	Has stolen in a face-to-face encounter
Forced someone to have sex	Has set fires to damage property
Has destroyed property on purpose	Has broken into a building or car
Often lies to "con" others	Has stolen without breaking and entering or face-to-face encounter
Starting before age 13, often skips school	Has run away from home at least twice
Starting before age 13, often stays out late against parental rules	

Note. The child must have shown at least three conduct-disordered behaviors in the past year and one in the past 6 months. The behavior must cause problems with friends or family or at work. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

What Does the Future Hold for Children with CD?

Research studies suggest that about one of every two children with CD will have persistent and severe problems. A study I did with my colleagues at Massachusetts General Hospital in the late 1990s was consistent with these findings: Half of the kids studied did not have CD by early adolescence, 4 years after the original diagnosis. There is no direct treatment for CD, and no studies have been done on the long-term effects of treating kids versus not treating them (for the ethical reasons mentioned in the ODD section), but clinically we do know that children who are treated for CD and associated disorders are more likely to do better in the future than kids who are not treated. A child who has difficulties getting along with friends and family and whose family environment is marked by parental conflict and little bonding among family members is more prone to persistent CD. The child with persistent CD is at highest risk for two malignant outcomes: drug abuse and criminality.

Although many youth with CD do not engage in illegal or antiso-

cial behavior throughout life, many are headed for an unhappy future. They are at high risk for physical injuries from accidents and fighting. Because they often become sexually active in adolescence, they are at risk for unwanted pregnancies and sexually transmitted diseases, including AIDS. It's not just their ability to obey society's laws that is affected by this psychiatric disorder but their ability to perform general tasks of living. Adults who don't follow rules and have violent outbursts usually can't hold a job for long, and when they do, they rarely advance. This can lead to a downward spiral of demoralization and anger that worsens their antisocial behavior. Similarly, antisocial behavior interferes with establishing long-term love relationships and raising a family. Because antisocial adults have a "me first" attitude, their needs come before those of society, their spouses, and their children. If they want to spend half their salary on booze and drugs rather than clothes for the kids, they will. If they cannot persuade their spouses or children to their point of view, they may resort to verbal and physical abuse. As a result, antisocial adults who try to have families often end up creating a chaotic family environment that leads to divorce.

Is Conduct Disorder Behind the Youth Violence of Today?

Six of the 15 behaviors included in the diagnostic criteria in Table 4.3 involve physical violence. Not all children with CD will be guilty of violent behavior toward people, but many are. In our study, mentioned earlier, 50% of the kids with CD had started a fight; 40% had used a weapon; 40% had been cruel to people; and 80% had lied. The Children's Defense Fund tells us that, on an average day, 237 American youth are arrested for a violent crime. The U.S. Department of Justice estimates that 1 in 10 schools report at least one violent crime to authorities each year. In a 1990 Michigan survey, nearly half of inner-city youth said they could obtain a gun within 1 day; about half had seen someone shot or knifed; and one in five had seen someone killed. Similar situations exist in other cities. There is no doubt that youth violence is an American tragedy of epidemic proportions. Is CD behind this trend?

Politicians and pundits have postulated many reasons for America's youth violence: the availability of guns, the decline of family values, poor parental supervision, illicit drug use, poverty. I believe CD

and its associated psychiatric conditions must take a prominent place on this list. Some writers argue that we should not medicalize crime, that crime is behavior rooted in lawlessness and immorality rather than illness, and that punishment, not treatment, is the correct consequence. But we have plenty of evidence that some crime is caused by psychological illness. John Lennon's murderer suffered from schizophrenia, as did the man who attempted to kill President Reagan. Since we know that violence can be part of CD, it's important to treat the illness as soon as its signs appear. If we ignore conduct-disordered behavior in our children, we run the risk of fueling America's tragedy of youth violence. If we detect symptoms early and understand their cause, we reduce that risk by seeking effective treatment. For CD this process is complicated by the fact that some cases are caused by an underlying mood disorder. If you think your child has CD, read the next chapter to see if he or she has a mood disorder as well.

In the meantime, consider the signs of CD an alarm. This is another example of why you should get a professional evaluation of your child's behavior without delay.

A Roadmap to Treatment: CD*

Medicines

No specific pharmacological treatment for ODD. Stimulants may reduce aggression. Treatment for a co-occurring mood disorder may help.

Psychological treatment

1. Parent and child education: about nature of the disorder and its treatment
2. Parent management training
3. Collaborative problem solving
4. Cognitive-behavioral therapy

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

SUBSTANCE USE DISORDERS

What Are Substance Use Disorders?

Substance use disorders describe problems that arise from the use of alcohol, drugs, or nicotine. As children grow into adolescence, they face peer pressure and opportunities for substance use in school, at parties, or when visiting friends. Parents try to limit these opportunities but cannot eliminate them altogether. As a result, by the end of high school, many teens will have tried alcohol or drugs. Fortunately, most of these will not go on to develop serious substance use problems.

FAST FACTS about Substance Use Disorders

1. Affect about 15% of high-school-age teens
2. More common in boys than girls
3. Usually start in adolescence
4. Often seen with other psychiatric disorders

We don't know all the details about why some people progress from first use through frequent use to disorder. But we do know that substances interfere with the normal functioning of the brain to create a strong sense of pleasure. Due to the complex interplay between genes and environment, some people are more likely than others to gradually undergo brain changes that make them crave the substance to such an extreme that it dominates their lives. These people have a substance use disorder.

In this section, I'll help you understand how doctors distinguish between substance use and substance disorders, but as a parent, you should be concerned if your child shows any signs of substance use. Don't wait for a disorder to develop before you take action. No one would consider it "normal" for a 4-year-old to have a single drink or cigarette. But what most parents wonder is when they should worry about older kids—when a teenager goes past the single experiment and starts using drugs, alcohol, or cigarettes on a regular basis, no matter how frequently? At what age should any regular use be con-

sidered a problem? Is zero tolerance for alcohol and cigarettes before the legal drinking and smoking age the right approach? These are questions that parents wrestle with every day, and because the criteria for substance abuse and dependence are aimed at adults and not separately at children, they are difficult to answer using diagnostic criteria alone.

Many roads lead to substance use disorders, but all start with a first drink, a first puff on a marijuana cigarette, a first snort of cocaine, or the first use of some other drug. Your child is likely to consider this first use harmless. It is not. It is true that not all first users will become regular users and not all regular users will develop disorders. But, because you have no way of knowing how far your child will progress, you need to be concerned about substance use at its earliest stages.

Later in this section I'll describe ways that you can identify substance use in your child so that it does not evolve into abuse or dependence. There is no doubt that substance use can be harmful in many ways, and there is no doubt that substance use can be a sign of another problem that needs to be addressed. Keep in mind that the criteria for diagnosing substance abuse or substance dependence don't attempt to explain what motivated a child or a teenager to use drugs, drink alcohol, or smoke cigarettes in the first place. Theories about what leads youngsters to this behavior abound. As mentioned, saying "yes" instead of "no" to drugs may be the result of the impulsivity of ADHD. A child with a mood disorder (see Chapter 5) or an anxiety disorder (see Chapter 6) might try drugs or alcohol or cigarettes in an attempt to self-medicate—that is, to try to find something that will make him or her feel better. There are numerous other paths by which a child or teen could start using substances. If your child is using any substance, you need to find out why, whether or not the child qualifies for a diagnosis of substance abuse or dependence.

Substance use disorders are divided into substance abuse and substance dependence. We use the diagnosis of substance abuse to describe people who show a repetitive pattern of substance use that leads to serious problems in their lives. As you can see from Table 4.4, the criteria for substance abuse do not include any mention of the amount of substance use. Instead, the focus is on four areas where recurrent substance use causes problems.

TABLE 4.4. Behaviors Leading to the DSM-IV Diagnosis of Substance Abuse

Behaviors related to the use of the substance lead to impairments or distress as indicated by one or more of the following occurring in a 1-year period:

1. Recurrent substance use leads to failures at home, work, or school.
2. Recurrent substance use creates dangerous situations.
3. Recurrent substance-related legal problems
4. Continued use of the substance in the face of persistent problems caused by the substance

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

At work and school, teens with a substance disorder will show poor performance and will frequently arrive late or not at all. Their substance use leads to suspensions or expulsions from school and chronic conflict with family members. Substance abuse leads teens into dangerous situations such as driving or operating dangerous tools or machines while drunk or high. It also leads to legal problems due to disorderly conduct, traffic violations and accidents, or thefts motivated by the need to buy drugs. Substance abusers often continue to use substances even though this causes serious problems.

You will find that one of the most important lessons to learn from the substance abuse criteria in Table 4.4 in what is not included—any mention of the amount of substance used by the person being diagnosed. Doctors will ask questions about this, but they have no hard-and-fast rules that state, for example, if patients drink more than a six-pack of beer each day, they are abusing alcohol. Instead, they focus on whether and how their use of alcohol leads to problems in their lives.

It is true that the likelihood of having problems increases with the amount of substance use, but the focus on impairment is essential if doctors are to discover and diagnose substance abuse in their patients. Jake, a 21-year-old college student, would rarely drink during

the week but usually drank heavily and got drunk on the weekends. He did not use other substances. About one weekend each month he and his friends would go on a drinking binge, each drinking two six-packs of beer and some hard liquor. Jake's parents were understandably concerned. Was he a substance abuser or just a normal college student enjoying his free time?

To answer that question, I needed to figure out how alcohol use had affected Jake's life. Here is what I learned. Initially, drinking did not affect his life, but after 6 months of drunkenness on weekends and periodic binges, Jake's grades took a nosedive from As to Cs, and his girlfriend broke off their relationship. He admitted to driving while drunk and being in a car driven by a drunken friend. They, in fact, had had one close call when his friend lost control of the car and nearly drove off a bridge one night. Because of these problems and impairments, it was clear that Jake had an alcohol use disorder.

Substance abuse sometimes leads to a more serious disorder known as substance dependence. The main difference between the two disorders is that the patient with substance dependence shows physiological or psychological changes due to prolonged substance use. These changes show patients have reached a point where the substance dominates their lives, and physical symptoms or behavior show they cannot do without the substance. The patient with substance dependence is what most people envision when they hear the term *alcoholic* or *drug addict.*

Table 4.5 presents the main features of the criteria doctors use to diagnose substance dependence. The two physical signs of dependence are tolerance and withdrawal. Tolerance occurs when the brain adjusts to the effects of the substance so that as the substance is used regularly for a period of time, more is needed to achieve the effects sought after by the drug user, effects such as increased pleasure and reduced anxiety. Many social drinkers experience tolerance. At first, one glass of wine produces relaxation and reduces social inhibitions. Eventually, two or three glasses are needed to yield the same effect. Another common example is cigarette smoking. Many smokers smoke more than 20 cigarettes each day even though one or two were enough when they started. In fact, if they had smoked 20 per day when they started, they would have become very sick because their body had not yet adapted to nicotine.

After a person has used a substance at high levels for some time, stopping its use abruptly will lead to unpleasant withdrawal symptoms. The nature of these symptoms depends on the substance that has been used. For example, symptoms of alcohol withdrawal include insomnia, vomiting, anxiety, seizures, agitation, and hallucinations. Symptoms of cocaine withdrawal include fatigue, sad mood, vivid and unpleasant dreams, disrupted sleep, and increased appetite.

In addition to the physical symptoms of tolerance and withdrawal, substance dependence leads to changes in behavior. One

TABLE 4.5. Behaviors Leading to the DSM-IV Diagnosis of Substance Dependence

Substance use leads to impairments or distress as indicated by three or more of the following occurring in a 1-year period:

1. Tolerance as indicated by one of the following:
   - The patient increases the amount of substance use to maintain its desired effects.
   - The patient does not increase substance use and desired effects get weaker.
2. Withdrawal as indicated by one of the following:
   - Stopping or reducing substance use after a period of heavy and prolonged use leads to physical symptoms specific to the substance.
   - The patient takes the substance to avoid or relieve the physical symptoms of withdrawal.
3. The substance is taken in larger amounts or over a longer period of time than was intended.
4. The patient has a persistent desire or failed efforts to reduce substance use.
5. Much time is spent obtaining, using, or recovering from the substance.
6. Important social, work-related, or recreational activities are reduced due to substance use.
7. Continued use of the substance while knowing that it has created a persistent or recurrent psychological or physical problem.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

behavioral effect of tolerance is that the patient uses the substance in larger amounts or over a longer period of time than was originally intended. Patients with substance dependence have strong cravings for the substance and, if they have tried to reduce their intake, have failed. They may become obsessed with the substance to the point of spending a good deal of time obtaining the substance, using it, and recovering from its effects. These substance-related behaviors interfere with normal living to the point where social, work-related, or recreational activities are reduced to make time for substance-related activities. Patients with dependence continue use of the substance even though it has created persistent psychological or physical problems.

How Do Parents Identify Substance Use before It Leads to Disorder?

In a 2001 survey by the U.S. Centers for Disease Control and Prevention, 78% of high school students said they had tried alcohol, and 42% had tried marijuana. Fewer had tried cocaine (9%) and heroin (3%). Sadly, nearly a third of all high school students had been offered, sold, or given an illegal drug on school property at least once that year. Many children who try substances don't develop a serious disorder. At some time in their youth, nearly half of high school students will have tried an illegal drug and three quarters will have used alcohol. Yet only 15% will develop a substance use disorder.

Because substance use is so prevalent among teens and you can't know whether your child will be one of the minority who develop a disorder, every parent should be on the lookout for its early signs. It's natural to prefer to avoid looking for these signs. To do so seems to require that you suspect your child of using drugs, a suspicion that a creates fears, uncertainty, guilt, and frustration in parents. But there is a difference between suspicion and alertness. Learn about behaviors that often indicate substance use and notice if they start to appear in numbers. The more of these behaviors shown by your child, the more you should be concerned and the more likely it is that professional help is warranted.

TABLE 4.6. Slang Terms for Drugs of Abuse

Drug of abuse	Slang term
amphetamine	bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers
anabolic steroids	roids, juice
barbiturates	barbs, reds, red birds, phennies, tooies, yellows, yellow jackets
benzodiazepines	candy, downers, sleeping pills, tranks
cocaine	blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot
codeine	Captain Cody, Cody, schoolboy, doors and fours, loads, pancakes and syrup
fentanyl	Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash
flunitrazepam	forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies
GHB	G, Georgia home boy, grievous bodily harm, liquid ecstasy
hashish	boom, chronic, gangster, hash, hash oil, hemp
heroin	brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse
inhalants	laughing gas, poppers, snappers, whippets
ketamine	cat Valiums, K, Special K, vitamin K
LSD	lacid, blotter, boomers, cubes, microdot, yellow sunshines
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed
MDMA	DOB, DOM, MDA, Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC
mescaline	buttons, cactus, mesc, peyote
methamphetamine	chalk, crank, crystal, fire, glass, go fast, ice, meth, speed
methaqualone	ludes, mandrex, quad, quay
methylphenidate	JIF, MPH, R-ball, Skippy, the smart drug, vitamin R
morphine	M, Miss Emma, monkey, white stuff
nicotine	bidis, chew, cigars, cigarettes, smokeless tobacco, snuff, spit tobacco
opium	big O, black stuff, block, gum, hop
PCP	angel dust, boat, hog, love boat, peace pill
psilocybin	magic mushroom, purple passion, shrooms

Note. Based on: http://www.nida.nih.gov/DrugPages/DrugsofAbuse.html.

You may hear warning signs in your child's language. You may hear them discussing a movie with friends and get the impression that they know more than you thought about drugs of abuse or their methods of administration. You may hear them using some of the slang terms for drugs listed in Table 4.6. Although they may have learned such terms from TV or the movies, their knowledge and use of such terms should raise your level of suspicion.

You clearly should be worried if your child possesses drug paraphernalia. Marijuana users may have rolling papers, plastic sandwich bags, small cans for storage, pipes, and clips for holding marijuana cigarettes. Inhalant abusers may have cleaning rags, empty spray cans, tubes of glue, soft drink cans, or ping-pong balls. Heroin users need needles, syringes, cotton balls, teaspoons, and medicine droppers. Cocaine users need glassy surfaces, mirrors, single-edged razor blades, rolled-up paper tubes, straws, and nasal sprays. Crack users need pipes, small glass vials, colored stoppers, Pyrex tubes, and small screens. Pictures of some of these items are available at www.ohsinc.com. That site also shows pictures of drugs so you may be able to identify any unusual pill, powders, or other substances you might find.

Another serious sign of substance use would be smelling alcohol or marijuana smoke on your child's breath or clothing. A related clue would be heavy use of perfume, breath mints, mouthwash, air freshener, or any other method to create a strong smell to cover up alcohol or drug use. Burning incense in the bedroom does not mean your child is using drugs, but you should consider it as a possibility.

Do your best to keep track of any alcohol, cold medicines, cough medicines, or prescription drugs that are in the home. Do these go missing from time to time? Are they being depleted more quickly than expected? Also keep track of glue and cleaning solutions. Inhaling these is a popular method of getting high. In fact, 13% of high school seniors have used inhalants at least once. Does your child use glue or cleaning solutions more frequently than seems necessary? Does he keep a spare chemical-soaked cleaning rag in his room?

Regular drug users need money to buy drugs. Does your child always need money? Are you sure it is being spent on the clothing or

entertainment it was requested for? Have money or valuables disappeared from your home? Has your child been caught stealing? Some teens will sell drugs to finance their habit. If successful, they may have too much money, so you should also be concerned if your teen is able to buy expensive equipment, cars, or other items that you think he cannot afford.

Other signs of drug use are seen in sudden changes of behavior. Table 4.7 lists some examples. Because teens who use drugs will try to hide their use from parents, any signs you observe should be taken seriously, especially when they co-occur with other signs. When you evaluate these signs in your child, think in terms of changes in behavior. If you have an oppositional child who has been disrespectful of family rules all his life, continued oppositional behavior in adolescence would not be an early sign of drug abuse. But if you had a well-

TABLE 4.7. Warning Signs of Substance Use in Children

Loses interest in family or school activities	Change in personality
Disrespectful of family rules	Lies about activities
Withdraws from responsibilities	School grades worsen
Verbally or physically abuses others	Skips school or is frequently late
Goes on eating binges or loses appetite	Loses interest in learning
Mood swings or outbreaks of temper	Sleeps in class
Violates family curfew	Job performance worsens
Avoids telling you plans with friends	Stops doing homework
Spends lots of time alone in room	Poor attitude toward sports or other activities
Reduced memory or attention	Changes friends
Confused, destructive, or agitated behavior	Paranoid thoughts
Doesn't seem as happy as he or she used to be	Worsening of physical appearance
Secretive about activities and possessions	Large weight loss or gain
	Wears sunglasses for no reason
	Frequently has red eyes or carries eye drops

behaved child for 14 years and suddenly find him or her ignoring family rules, being violent, and stealing, you would be concerned. As a general rule, drug use leads to changes in behavior and attitudes that parents and teachers will experience as beyond what is usual for the child.

Of course, many normal teens who do not use drugs will show some of these signs. Adolescence is a time of turmoil, and teens can be abusive, moody, argumentative, and disrespectful. If these behaviors persist and lead to problems at home or school, they may be worthy of professional evaluation as they could indicate not only substance use but also another psychiatric disorder.

What Does the Future Hold for Children Who Abuse Alcohol or Drugs?

Tolerance and withdrawal set a cruel trap for drug users. When they start using, drugs provide a high that makes them feel better than before. But as they continue using, they become tolerant to these effects and need more and more drug to retain that high feeling. Eventually, their drug habit gets too expensive. When they cannot increase their dose, they no longer become high. If they stop the drug, they suffer the unpleasant symptoms of withdrawal. At this stage, they use drugs not to get high but to avoid withdrawal. When that happens, some turn to crime to finance their habit. Their drug use also affects their physical health, making them more susceptible to disease, and it impairs their judgment, leading to disabling and sometimes deadly accidents.

The serious problems caused by substance use were highlighted in a report from the U.S. Department of Health and Human Services, which estimates that drug and alcohol disorders contribute to the deaths of more than 120,000 Americans each year. The use and abuse of these drugs costs the United States $294 billion annually in health care costs, extra law enforcement, auto crashes, crime, and lost productivity. Fortunately, the National Institute on Drug Abuse estimates that treatment of substance abuse substantially reduces drug use and crime while it increases the employment prospects of those treated for substance abuse.

A Roadmap to Treatment: Substance Use Disorders*

Medicines

1. Medicines to manage short-term physical withdrawal symptoms (e.g., benzodiazepines for alcoholics)
2. For opiate addicts: methadone, levo-alpha-acetylmethadol (LAAM), naltrexone
3. For nicotine addicts: nicotine patch, nicotine gum, bupropion
4. For alcohol addicts: naltrexone, disulfiram
5. Medical tests to monitor drug use
6. Treatment for co-occurring disorders may help.

Psychological treatment

1. Parent and child education: about nature of the disorder and its treatment
2. 12-step self-help program (e.g., Alateen, Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous)
3. Comprehensive program addressing medical, psychological, social, vocational, and legal problems. Should teach substance resistance, problem solving, and interpersonal skills along with constructive activities to replace substance use.
4. Cognitive-behavioral or interpersonal therapy

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

Drug Use Prevention Education

Don't wait for any drug use to start before you show your concern. Drug use prevention education begins at home. When your child becomes old enough to understand the idea of drug use, you need to state in clear and unequivocal terms that drug use is harmful and should be avoided at all costs. Don't wait for him or her to become a teenager; start as early as possible.

Don't limit your antidrug message to a vague comment indicating that drug use is unacceptable, bad, wrong, or immoral. Indicating in this manner that your thoughts about drug use are part of your family's value system is good, but it's not enough. You also need to make some concrete, practical points. I suggest the following:

1. Drug use harms the brain both temporarily, when the drug is used, and permanently due to long-term effects. These effects make it difficult to think, learn, and live a normal life.
2. Drug use is illegal and could land your son or daughter in prison some day.
3. Drug use will stop your children from achieving whatever goals they set for themselves in life.

Children have a short attention span, which cannot tolerate tedious lectures. You need to send brief but frequent antidrug messages which, ideally, are linked to relevant events. When you are watching a TV show or movie together and drug use comes up, use the opportunity to send your message. If you hear some news about a drug-related arrest, tell the story (briefly) at the dinner table and send your message. If your child brings home drug use prevention education materials, go over these together. Send your message. Remember, as the parent of a young child, your message will be more powerful than anything a teacher can communicate to your child.

Chapter 5

Moodiness

Every normal child becomes moody from time to time, during certain phases of development or in response to stresses in the environment, such as starting at a new school or moving to a different community. In most children, these bouts of ill mood are self-limiting. They end when the memory of an aggravating event fades into the dim past or when the child is diverted by friends or pleasant activities. Or they simply run their course the way many minor developmental blips subside in short order. But not all bad moods pass. In some children they persist, disrupting the child's functioning and throwing the lives of the whole family into havoc.

If you have a child that you would describe as "moody," "temperamental," "touchy," "cranky," or "a real sad sack," you may feel as if your household is ruled by your child's emotional ups and downs. Maybe your child snaps or whines or grumbles at the most benign suggestions, making you all feel as if you're walking on eggshells around her. Maybe your child seems so blue that you find yourself lying awake at night trying to conjure up new ways to make him or her happy—and agonizing over the possibility that something is seriously wrong when a 9-year-old walks around as though carrying the weight of the world on his or her shoulders.

Excessive moodiness can cut quite a destructive swath through the lives of children and everyone around them. Emotion, after all, plays a powerful role in behavior and thought. As we mature, we learn to control our everyday moods and to temper behavior that might flow from them. But children have not yet mastered this type

of self-control. Even those with minor mood problems are likely to act out. Those with diagnosable mood disorders can be, to put it bluntly, a nightmare to live with. But, of course, those hurt most are the moody children themselves. Kids who are depressed or manic often find it hard to move with ease through daily routines and can drive away friends with their problematic behavior. In addition, there is no doubt that mood problems affect children's ability to develop their intellectual powers. The majority of kids who have mood disorders will have some sort of problems in school, ranging from periods of lower-than-expected achievement to chronic difficulties with mental tasks. Bipolar kids almost always have trouble in school, because they're very disruptive. To make matters worse, many children with mood disorders also have learning disorders.

Unfortunately, the fact that mood problems often manifest themselves as disruptive behavior and academic problems can make mood disorders especially difficult to diagnose. Does the child who seems dejected all the time and inattentive at school suffer from ADHD or depression? Is the child having a hard time paying attention to the teacher because his or her mood is so low, or is the child's mood so low because the academic failures resulting from ADHD have seriously eroded his or her self-esteem? As I'll explain later in this chapter, the child may have both disorders (or a mood disorder and some other co-occurring disorder), and because both can be so devastating to the child's future when left untreated, many diligent practitioners today will diagnose and treat both if there is a shadow of a doubt about whether the child has only one or the other. The challenge for parents lies in the fact that the child's primary *symptoms* might not seem to be emotional ones, whereas the primary *diagnosis* may very well be a mood disorder. It will take all of your powers of observation, honed in Chapter 1, to contribute to an accurate diagnosis of your child.

Clinicians are challenged even further by the fact that mood disorders look very different in children and adults. Practitioners mistake depression in kids for other chronic problems like ADHD, ODD, and CD because depression usually goes on for weeks or months in a child instead of the 3 or 4 weeks at a time typical of adults. Also, the main mood disturbance seen in depressed adults is typically sadness. For children, it is irritability. In fact, it wasn't until

relatively recently that the mental health field recognized depression as prevalent among young people. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III), published in 1980, recognized that depression could occur in children and teenagers but underestimated the prevalence of depression and did not even mention bipolar or manic symptoms in children or adolescents. DSM-IV, published in 1994, clearly recognized the incidence of depression in children and mentioned adolescent onset of bipolar disorder. By the time of this writing, in 2002, the mental health field was well aware of the occurrence of bipolar disorder in children. Our understanding of mood disorders in children has advanced significantly in the last 20 years. DSM-III did not even include mood disorders in the section that lists disorders that usually first appear in childhood and adolescence; even DSM-IV (1994) does not classify them this way. Yet we now know that depression occurs in up to 5% of all kids.

How do you determine when moodiness should be treated and when it is just the typical age-related angst? Substance abuse (see Chapter 4) may be one indication, though there you run into the chicken-and-egg problem: Kids who abuse substances often appear moody, but depression can also lead to substance abuse. Environmental stressors can cause moodiness, and adolescence certainly brings significant changes, from the pressures of sexuality to dealing with demanding academics and a new social pecking order. As for most disorders, the key to distinguishing normal moodiness from a disorder usually lies in the level of impairment, the duration of the problem, and the nature of the child's symptoms. This last point is crucial. Although disturbed mood is seen in all mood disorders, these disorders also show many symptoms unrelated to the child's mood. Learning about these symptoms in this chapter will help you distinguish normal moodiness from mood disorders.

One mistake that many parents make is assuming that being able to identify an environmental stressor for a child's moodiness means that it's not a disorder and need not be treated. The fact is that prolonged mood problems can be very debilitating, and even if there is an identifiable environmental stressor, any child who has suffered for an extended period of time should be evaluated and treated as appropriate. The existence of an environmental stressor may or may not influence the choice of treatment mode.

Whatever your child's age, his or her emotions and behaviors probably puzzle and frustrate you if the child exhibits extremes of moodiness. Children who become extremely sad may cry uncontrollably and have very low self-esteem. They cast a bleak cloud of sadness wherever they go. Undoubtedly you try to cheer your child in this case, and when you fail you end up feeling inadequate, blaming yourself for your child's unhappiness. Or maybe your child gets extremely irritable for long periods of time. Excessively irritable children are easily annoyed. They whine, shout, and complain, chronically aggravated by the world around them. Sometimes they become quite aggressive, hurting family pets, siblings, or friends, lashing out at others, physically or verbally, for no apparent reason. In cases like these you may start to wonder about your child's sanity. Other children with mood disorders get so excitable that they become totally out of control, involving themselves and others in dangerous activities. Extreme irritability and overexcitability will erode the patience of even the most hardy parent, leading to parental anger and family conflict.

Yes, moodiness can be normal. But when your child's moodiness is accompanied by many other symptoms (see the symptom tables later in this chapter), you should waste no time having your child evaluated by a mental health professional.

MAJOR DEPRESSIVE DISORDER

What Is Major Depressive Disorder?

In everyday language, people use the word *depression* to mean sadness. This creates a barrier to understanding major depressive disorder because, although sadness can be a feature, it is only one of many features and (you may be surprised to learn) is not a requisite for the diagnosis. The diagnosis of depression does require the child to show a massive disruption of mood, but this disruption may occur as either profound sadness or persistent irritability. And research reveals that most children with depression are usually extremely irritable, not sad.

Don't underestimate how crucial it is to understand the irritable nature of child depression. Children with irritable depression appear oppositional, arrogant, disruptive, and mean. Sometimes they are vi-

olent. Frequently they also have conduct, oppositional, or attention-deficit disorders. They irritate parents and teachers and alienate siblings and friends. On the surface they seem to be disruptive children, so they are often punished and sometimes referred to a mental health practitioner for the treatment of unruly behavior. But, because the cause of their disruptive behavior is an irritable depression, direct treatment of the problematic behavior will usually fail.

FAST FACTS about Major Depressive Disorder

1. Describes children who are persistently irritable or sad
2. Diagnosed in 2–5% of children
3. Early onset more common in boys; later onset more common in girls
4. Can start in childhood or adolescence
5. Often seen with ADHD, conduct, and anxiety disorders

In some cases, it takes many years before a health professional realizes that this type of child needs to be treated for irritable depression. That delay in treatment wastes many years of childhood and allows the tragedy of depression to be compounded by its long-term effects—lowered self-esteem, family disharmony, substance abuse, academic difficulties, loss of interest in others, and failure to develop the social/recreational side of life, even risk of suicide.

Of course, not all irritable children are depressed. Some irritability is normal in varying degrees at different stages of your child's life. For sure, you can expect your teenage child to have bouts of irritability and anger for no clear reason. Even chronic irritability in a teenager could be perfectly normal as long as it is sporadic rather than constant. A 5-year-old's irritability is probably not a concern when it lasts for the first 3 weeks of kindergarten and occurs only right before and right after school, dissipating as the day goes on and the stress of school fades. An 11-year-old girl could have bouts of normal irritability related to hormonal changes. As Table 5.1 shows (and as explained fully in Chapter 2), the distinction between an everyday problem and

a diagnosable illness is based on severity, frequency, and duration of the symptoms, plus the degree of impairment they cause.

You will see from the table that, for a child to be considered depressed, his or her sad or irritable mood must occur most of the day nearly every day for at least 2 weeks. We're talking about a child whose bad moods are pervasive and whose good moods are truly rare. (I say "truly" to remind you that you need to use the observation methods in Chapter 1 to get an objective view of how bad things really are. With even a slightly moody child parents can become oversensitive and see crabbiness that isn't there just because they expect it—especially if the parents have any propensity toward moodiness themselves.) The table also shows that there is more to depression than bad moods. To be considered depressed, not only must your child show pervasive and extreme bad moods for 2 weeks, but during that time he or she must also show four of the other symptoms nearly

TABLE 5.1. Symptoms Leading to the DSM-IV Diagnosis of Major Depressive Episode

At least one of the following:
Sad or irritable mood most of the day nearly every day for at least 2 weeks
Loss of interest or pleasure in activities
Four or more of the following nearly every day:
Large weight gain or loss or (or failure to make expected gains) or marked increase or decrease in appetite nearly every day
Appears to be agitated or physically slow
Does not sleep well or sleeps too much nearly every day
Is fatigued nearly every day
Has problems concentrating or making decisions
Feels worthless or guilty nearly every day
Has recurrent thoughts of death or suicide or has made a suicide plan or attempt

Note. The symptoms do not count if caused by a medical condition or the use of drugs or alcohol. Symptoms must cause substantial distress or impairment. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

every day for the 2-week period. This rule is important because some kids, especially teens, can be sad or irritable for 2 weeks or more even if they are not depressed. But they will not be diagnosed with depression if they do not show the other symptoms of the disorder. The other symptoms include changes in thinking patterns, physical symptoms, and changes in behavior. The child who is depressed becomes distractible and indecisive. He or she finds it difficult to concentrate on schoolwork or activities with friends. The way the child thinks about him- or herself and the world around him or her takes on strong negative overtones. He or she may feel worthless as a student, friend, athlete, or child. You may also hear expressions of hopelessness as the child describes a bleak future. These are compounded by thoughts of helplessness, strong and unrealistic beliefs that he or she cannot make changes to improve a difficult situation. When all these negative thoughts are taken to their extreme, the child will wish that he or she were dead and may even speak of suicide.

Some signs of depression are purely physical and have no apparent link to mood. A weight loss or gain of more than 5% a month should be of concern, as should an appetite change of 5% or more every day. A child with depression may experience disrupted sleep: The child either cannot sleep soundly or oversleeps. He or she can be fatigued easily and may complain about a low energy level.

Depression also shows up in behavior. The child with irritable depression becomes angry and aggressive, lashing out either verbally or physically at the world. Some children with depression spend much of their time alone and are minimally engaged in activities that used to bring them pleasure. When they do participate, they don't enjoy them or they quickly explode in frustration.

If you consider the symptoms of depression one or even two at a time, it's easy to think that nearly all kids, especially teens, are depressed at one time or another. That, of course, is not true. Although many of the symptoms taken singly may be common, when we require that they all occur at the same time and persist nearly every day for 2 weeks, the diagnosis of depression is not common at all. This is why it is so important that the child's behavior, feelings, and thoughts be evaluated thoroughly and accurately. A child who shows the behavioral signs just described may not be depressed but instead might have ODD, ADHD, or CD (see Chapter 4). Listlessness and

lethargy and sleep disturbances could be caused by medical conditions as easily as depression. Irritability could be caused by a wealth of things other than depression: disruptive behavior disorders such as ODD, anxiety, and reactions to chronic stresses. A child who is suffering from major depressive disorder will fit the full diagnostic picture created by the DSM-IV criteria.

Even when those criteria are met, however, one more diagnostic criterion will protect doctors from overdiagnosing depression. The symptoms must cause substantial distress or impairment. The child who becomes depressed will show a clear change, such as a decline in grades, loss of interest in usual activities, trouble getting along with others, loss of a job he or she has had for a while, or quitting the football team, choir, band, Scouts, or other group activity. Teachers, coaches, or other adults may tell you that something has changed, something seems wrong.

Although they are not discussed separately here, you should know that there are other, milder forms of depression suffered by children. Dysthymia may be the most common. To be diagnosed with dysthymia, a child must have suffered the first symptoms listed for at least a year rather than 2 weeks and must also have at least two of the next group of symptoms. Children with dysthymia may seem to be constantly down or blue, but their moodiness will not look as severe as in major depressive disorder.

What Does the Future Hold for Depressed Children?

Although some children with depression will recover within 2 years of being diagnosed, about three in four will have further bouts of depression in the future. Many will grow up to become adults who suffer from depression. One study contacted the families of children with depression 15 years after the child's initial diagnosis. Four percent of the children had committed suicide. This risk for suicide and other adverse outcomes shows how important it is for depression to be recognized and treated as soon as possible.

We cannot predict with certainty which children with depression will continue to struggle with depression and which will never again have problems. But we do have some clues. Children with severe depression—as measured by the number of symptoms and the

degree to which they affect the life of the child and family—are more likely to be depressed in the future. For example, in one study four out of five hospitalized children with depression had to be rehospitalized within 2 years of being discharged from their first hospitalization. It's important to note, however, that hospitalization of children with depression is rare, usually limited to those who are a danger to themselves or others because they are aggressive or have suicidal thoughts, and to those whose depression is so severe that they need intensive supervision to figure out the best combination of medications and other therapies with which to treat them.

Typically, major depressive disorder tends to be progressive, starting out mild and gradually increasing in severity. Sometimes it stays mild, and sometimes it just goes away (while we know that it remits on its own in 30% of adults, this is trickier to determine for kids). We know that heredity plays a role in depression, and so do environmental stresses. But which children end up depressed in the first place, and which come out of their depression quickly may depend on other factors. Two children in the same family may both be biologically predisposed toward depression. When a parent dies, one may end up depressed (beyond the normal grieving process) while the other does not. It's possible that the latter has certain personality or intellectual strengths that make it easier to cope with the situation. (It's interesting to note, incidentally, that when two kids in one family have different problems, it's pretty clear that the key is not parenting.) Children who have an especially hard time getting along with other children are also at high risk for future depression.

As with other disorders, your parenting skills and the child's home environment will also contribute to the child's outlook for the future. Difficult home environments caused by poverty, parental fighting, child abuse, and other long-standing stresses will worsen depression and make persistence or recurrence more likely.

A potentially serious biological outcome of untreated depression was suggested by theoretical arguments and research completed at the National Institute of Mental Health. This research suggests that bouts of depression may damage the brain in such a way as to make future bouts more likely and more severe. In other words, it may be dangerous to think of child depression as a temporary condition that will dissipate with time. Instead, parents should be alert to the symp-

toms of depression so that children can be treated as soon as possible. Early treatment will not only limit the problems associated with the initial bout but may also prevent a mild depression from growing into an incapacitating disease.

Two potential outcomes of depression are extremely serious: drug and alcohol abuse, discussed in Chapter 4, and suicide—see the sidebar on pages 142–143.

A Roadmap to Treatment: Major Depressive Disorder*

Medicines

1. Tricyclic antidepressants (e.g., desipramine, nortriptyline, imipramine)
2. Atypical antidepressants (e.g., bupropion, venlafaxine)
3. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline)

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Interpersonal therapy

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

BIPOLAR DISORDER

What Is Bipolar Disorder?

As I mentioned at the beginning of this chapter, our knowledge of bipolar disorder in children has grown significantly in the last couple of decades. DSM-III (1980) made no mention of the disorder occurring in children or adolescents at all. By DSM-IV (1994) it was

Youth Suicide: A National Emergency

Despite its seriousness, suicide is a hidden problem. Many of us are concerned about the problem of violence in America. But for every two homicides, the last century has seen at least three suicides. Each year, about two thirds of a million people require emergency room treatment for attempted suicide.

Sadly, the rate of suicide among those ages 15–19 nearly doubled between 1970 and 1990 and more than tripled since the 1950s. There is a clear cohort effect: depression has also become more prevalent and onset has been earlier. Why depression and suicide are on the rise is a matter of ongoing debate. Is life more stressful than it used to be? Is depression really on the rise, or is it just that we are now more astute at recognizing it, more accepting of it, and more willing to identify it now that we have available treatments? Whatever the case may be, suicide is currently the fourth leading cause of death among children ages 10–14 and the third leading cause of death among those ages 15–24. Although recent years have seen a marked increase in youth suicide, however, the absolute risk is still very low.

In 1999 the Surgeon General of the United States convened a conference aimed at preparing a National Plan for Suicide Prevention. The conference report urged parents and health care providers to be attentive to signs that a child may be at risk for suicide. One of the strongest risk factors was depression, especially when the child with depression was also impulsive. Having additional mental disorders heightens the risk even further. Given that depression is often seen in children with ADHD and that impulsivity is a core symptom of ADHD, finding appropriate care for children with ADHD who are depressed should be a public health priority.

Other risk factors documented by the conference—and confirmed by the National Academy of Science's Institute of Medicine in its June 2002 report *Reducing Suicide: A National Imperative*—were easy access to lethal methods of suicide, especially firearms, unwillingness to seek professional help, lack of access to mental health care, poor problem-solving abilities, and exposure to other suicides, which can lead to "contagion." This last problem occurs when the suicidal behavior of one or several persons leads others to suicide attempts. Contagion usually occurs in discrete geographic areas and is worsened by newspaper and television coverage of suicide. The contagion effect is strongest among adolescents.

To reduce contagion, the Surgeon General's report recommended that news reports of suicide avoid the following: (1) simplistic explanations for suicide; (2) repetitive, ongoing, or excessive reporting of suicide; (3) sensational coverage of suicide; (4) "how-to" descriptions of

suicide; (5) describing suicide as a tool for accomplishing goals; (6) glorifying suicide or those who commit suicide; (7) focusing on the suicide completer's positive characteristics.

Although we know of some predictors of suicide, it is extremely difficult to predict with any accuracy which children will and will not try to kill themselves. Thus, the best advice to parents of children with depression is to find appropriate treatment for your child's depression and any co-occurring disorders. Youth suicide can be prevented by early and appropriate treatment, though the Institute of Medicine reported in June 2002 that methods to alleviate depression could be successful without reducing the incidence of suicide and vice versa. What's important for parents to know is that suicide is associated with the most severe depressions, and they're the hardest to treat successfully. And, by all means, whether you believe in gun control or not, prevent your child from having access to guns, which lead the list of suicide methods in the United States.

acknowledged that bipolar disorder could begin in adolescence. Since 1994 lots of research has been directed at the course of the disorder in children and teenagers, how it changes over time, how to treat it, what causes it, and how it's related to the adult version of the disorder. We now know that bipolar disorder can begin much earlier and is more widespread in youngsters than was once thought.

Children with bipolar disorder have a condition that expresses two extremes of mood. One extreme is depression, which I described in the preceding section. The other extreme is mania, an excessive state of elation or irritability. Sometimes bipolar disorder is referred to as manic–depressive illness to emphasize the nature of the disorder's two emotional extremes. Although not all children with depression will develop bipolar disorder, many bipolar children will experience depression before mania. Therefore, if your child has been diagnosed with major depressive disorder, be alert to the potential emergence of mania in your child.

We have already seen that there are two kinds of mood disturbances in depression—sadness and irritability. The same is true for mania, which can be expressed as either elation or irritability. The elated child with mania is extremely happy or silly and has unrealistic, grandiose beliefs about his or her own worth or abilities. In some cases these beliefs are so extreme that others view them as totally outrageous or crazy. For example, one teenager with mania believed

FAST FACTS about Bipolar Disorder

1. Describes a severe episodic or persistent dysregulation of mood that includes irritability, sadness, or euphoria
2. Diagnosed in less than 1% of children
3. Early onset more common in boys
4. Can start in childhood or adolescence
5. Often seen with many other psychiatric disorders

he was the president of the United States. Another was certain that he would discover a cure for cancer if he could raise enough money to set up a research institute.

Whereas elation is a common mood disturbance for adults with mania, children with mania are more likely to become extremely irritable, often to the point of downright rage and violence. The irritable child with bipolar disorder becomes verbally abusive and physically violent, throwing toys, kicking pets, yelling at parents, and assaulting siblings. These episodes of severe irritability often appear as sudden outbursts, having no conceivable motivation or purpose, and grow into prolonged storms of anger and violence. The severe nature of this irritability is the main reason why children with bipolar disorder sometimes must be sent to a psychiatric hospital. It's incredibly difficult for parents to cope with such outrageous, aggressive behavior.

Another possible symptom in children with bipolar disorder is hypomania, a milder version of mania that in fact can, according to the National Institute of Mental Health's consensus conference report on bipolar disorder (updated as of March 27, 2002), "even be associated with good functioning and enhanced productivity." This mild to moderate form of mania can lead to more severe mania in children with this disorder, but until it does, parents and the child him- or herself may have difficulty recognizing hypomania as part of an illness.

The author Danielle Steele, best known for her novels, also wrote *His Bright Light*, the story of her son, Nick Traina, an accomplished musician and effervescent personality who had bipolar disorder. Upon visiting her son in a psychiatric hospital, Steele described

him as constantly in a rage, "like a caged animal with nowhere to go." This anger is very typical of bipolar disorder in children and adolescents. But because extreme irritability can be a sign of depression as well a sign of mania, clinicians faced with an extremely irritable child must ask whether this child is manic or depressed. The answer to this question lies in the nature of the other symptoms seen in the child. If these follow the pattern of depression described in the previous section, the child is probably having a bout of depression. The clinician will consider the other features of mania given in Table 5.2.

Although depression is often the first phase of bipolar disorder, bipolar disorder in children can also have a sudden onset in which mania occurs right away. Bipolar disorder is defined by both depression and mania, so it's important to be able to recognize the separate signs of both—even though, confusingly, the signs and symptoms of both can occur simultaneously in children.

Many parents find it ironic that self-esteem, a quality sought for all children, can become a symptom of a psychiatric disorder. It's true that we usually view high self-esteem as a characteristic of children who are psychologically healthy, but in children with mania self-esteem is based not on an accurate view of their unique strengths and

TABLE 5.2. Symptoms Leading to the DSM-IV Diagnosis of Manic Episode

A distinct period of abnormally euphoric or irritable mood for at least one week.

Three or more of the following (four if the mood is irritable):

Inflated self-esteem or grandiosity	Decreased need for sleep
More talkative than usual or pressure to keep talking	Flight of ideas or racing thoughts
Very distractible	Increased goal-directed activity or agitation
Involved in pleasurable activities with high risk for painful consequences	

Note. The symptoms do not count if caused by a medical condition or the use of drugs or alcohol. Symptoms must cause substantial distress or impairment. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

weaknesses but on a gross exaggeration of their strengths and a complete discounting of their weaknesses. For example, one girl did not study for her final exams in high school because she was sure she would get all As (she didn't). Taken by itself, this could be seen as simple overconfidence, but when their daughter insisted that she could apply to medical school directly after high school because she already knew everything that college had to teach, her parents knew something was wrong. As with all diagnostic criteria, inflated self-esteem is a symptom of mania when it becomes frequent or extreme. Consider the boy who did not study for his final exams because he had been given special powers from God to instantly recall any fact when needed. You'd call that downright crazy. Clinicians would call it grandiosity, a belief in self-worth that is so extreme it appears as nonsense to others.

During periods of mania, children may appear extremely energetic. They rarely sleep yet have boundless energy. Not needing sleep is often the first symptom that marks the child as unusual. Danielle Steele noticed this in her son before the age of two. He needed little sleep and rarely napped during the day. Manic energy is also seen in speech. Children with mania may speak so quickly and for such long times that it seems as if their brain has turned on a switch to unleash a stream of language that cannot easily be turned off. Conversations are frequently one-sided. Others can't get a word in edgewise.

The rapid speech of a child with mania may be mirrored in the mind by racing thoughts, which move so quickly from one topic to another that his or her speech may be difficult to follow. The child literally seems to fly from one idea to another without pause and without ever reaching the idea he or she had intended to communicate. This flitting about from one idea to another may be due to the extreme distractibility of children with mania. They cannot focus for long on one object in their environment. Instead, their attention is easily drawn from one object to another. For example, they may abruptly end a torrent of speech and run off to watch a TV program they hear in the background.

Because of their excessive energy and tendency to move from thought to thought or activity to activity, the children with mania may appear very busy, almost hyperactively so. Some mothers of children

with mania who have had other children without the disorder will comment that the hyperactivity of the children with mania was obvious even before birth. They seemed restless and high-spirited even in the womb. The constant activity of children with mania can at first make them popular with friends, as they always have new ideas for games or other activities. But their tendency to switch from one thing to another soon alienates friends and relatives who usually prefer to complete one activity before pursuing another.

Children with mania seek out pleasurable activities even if they have a high risk for painful consequences. This leads to drug abuse, traffic violations, accidents, and high-risk sexual behavior. Children with mania easily accept dares from other children, which often lead to injury, legal trouble, and, sometimes, death. They may hatch wild schemes to make money that end up costing them dearly in the end. Consider the case of the teen who, before getting sick, had saved several thousand dollars. When he became manic he was convinced from watching a TV commercial that oak would be come a very valuable wood. So he drove around his neighborhood buying the neighbors' oak trees for $1,000 each until he ran out of money. Then he gave up the idea and moved on to another scheme when the army of oak tree investors he expected never materialized.

As you can see from the descriptions of depression and mania, people with bipolar disorder ride an emotional roller-coaster that rises to the highs of mania and plunges to the depths of depression. The pattern that this roller-coaster follows differs from person to person. In some cases, the manic and depressive bouts are separated by periods of normal emotion. But for others, periods of normal emotion are rare. Mania evolves into depression, which evolves into mania, starting the cycle over again. In some cases, manic and depressive bouts merge, leaving the person with both manic and depressive symptoms at the same time.

Unfortunately, children with bipolar disorder, as opposed to adults, usually have few periods of prolonged normal emotions. They are irritable nearly all of the time and can move quickly between symptoms of mania and those of depression. They do have some bouts of irritability that are more aggressive than others, but these bouts occur on a background of a continuous mood disturbance.

If your child has bipolar disorder, you will probably know that

something is very wrong. I say this because the symptoms of bipolar disorder will express themselves in serious, severe, and sometimes bizarre ways. Danielle Steele described her son as wetting his bed later than most kids do and defecating in the bathtub, on his pillow, and in other inappropriate places. Nick was angry and destructive much of the time. Clearly not a normal child, Nick grew out of some of these specific childhood problems but then showed equally serious problems as a teenager, from being so argumentative and insulting that family dinner conversation was impossible, to obsessing over events far ahead, to giving up normal personal hygiene. If elated during mania, kids can, as described earlier, also seem so delusionally euphoric or grandiose about their own abilities or plans that they may actually seem psychotic.

What Does the Future Hold for Children with Bipolar Disorder?

Bipolar disorder is one of the most impairing of childhood psychiatric disorders. Consider this: Children with bipolar disorder usually show the symptoms and impairments of ADHD and frequently are depressed. Many of them show high levels of antisocial and aggressive behaviors and will also meet criteria for conduct disorder (CD). Thus, they are at risk for all the adverse outcomes we described for children diagnosed with ADHD (Chapter 4), CD (Chapter 4), and depression. These adverse outcomes include learning disabilities, school failure, family stress, accidental injury, alcohol abuse, drug abuse, legal problems, difficulties with friends, violence, and suicide.

As you might imagine, having mania only worsens the risk for and intensity of these adverse outcomes. As a result, some children with bipolar disorder will at some time in their life require hospitalization. Most will require lifelong medication to control their symptoms and limit the damage caused by their many disabilities. Many will also benefit from intensive behavioral therapy aimed at helping the parents understand the nature of the child's mood disturbance, its link to disruptive behavior, and useful methods of parenting. Some youth with bipolar disorder will experience periods of severe dysfunction, as you can see in Danielle Steele's description of Nick as a teenager:

> Nick wasn't just a disciplinary problem. There were clearly times, many of them, when he was barely able to function. The simplest tasks were too much for him. He could not do chores, or have responsibilities. He could not feed a pet, remember to empty his waste basket, close the refrigerator door at four A.M. so everything in it didn't turn to mush, and making his bed was totally beyond him. He just *couldn't* do it. He wasn't just lazy, he was dysfunctional.

Perhaps the biggest determinant of future outcome for a child with bipolar disorder, however, is early diagnosis and treatment. The dangers of not treating bipolar disorder are soberly recounted in Danielle Steele's description of her son's life. Although he showed clearly abnormal behavior at a very early age, he did not begin to receive adequate treatment until he was a teenager. During his childhood, when Nick was persistently angry, destroying his toys, wetting his bed and smearing his feces, his psychiatrists told Danielle Steele that he had been spoiled and was reacting to the trauma of new stepsiblings from her recent remarriage. She was told that Nick was fine, that "all he needed was discipline." She writes, "Neither my pediatrician nor his school told me that they saw anything unusual about Nicky. . . . " Although Nick was eventually diagnosed as having ADHD, in his early teens another psychiatrist described him as a spoiled brat and said his problems were fairly minor. At age 15, when Nick was so severely depressed he rarely got out of bed, his psychiatrist still refused his mother's requests that he be given medication. She was told that "Nick was perhaps atypically manic–depressive, but he didn't want to be premature in his diagnosis" because "it was very unusual for a boy of fifteen to be manic-depressive."

Finally, she found a psychiatrist who diagnosed Nick with bipolar disorder and prescribed lithium, a mood-stabilizing medicine. She described the results as follows: "There was no denying the results three weeks later. Nick was a changed person. Happy, good-humored, sane, well-balanced, calm, and getting A's in school. The miracle had worked." Lithium worked well for Nick, but, when he was feeling better he would discontinue his treatment, which eventually led to a worsened condition and, at age 19, suicide. Although we cannot know for sure, it seems likely that Nick's life would have been saner, happier, and longer had he received appropriate treatment much earlier in his life. As I'll explain later, we are now developing

effective methods for helping people with bipolar disorder, including children and teens, manage their own treatment so that they can lead more normal lives with a long future.

The diagnosis of bipolar disorder is definitely improving, but the fact remains that this is a very difficult disorder to diagnose and to treat in children and adolescents, especially for clinicians who had been trained in an era when the disorder was believed to be rare. As mentioned at the beginning of this section, for many years clinicians believed that bipolar disorder was uncommon among adolescents and rare among younger children, in part because its manifestation was so different in younger people than in adults. This certainly led to underdiagnosis. But another complicating factor is a clinical principle called differential diagnosis. The principle of differential diagnosis tells clinicians to study a child who seems to have features of more than one disorder carefully and choose one diagnosis over the other. This rule is essential in some situations, especially when it is used to determine if a psychological disorder has been caused by an underlying medical condition. But it can be misused by clinicians faced with a child who seems to have two psychological disorders. In learning about the symptoms of mania you may have noticed many similarities between mania and ADHD. Both disorders show distractibility, impulsivity, and hyperactivity. Because of this overlap in symptoms, many children who satisfy the diagnostic criteria for mania also satisfy the criteria for ADHD. In this case, the devil of differential diagnosis forces the question: Does the child have bipolar disorder or ADHD?

Clinicians who embrace the principle of differential diagnosis may conclude that the child has ADHD. In part, this happens because the ADHD symptoms may emerge first. Then, when the irritable, aggressive storms of mania descend on the child and his or her family, the clinician decides the child has a severe case of ADHD, but not mania. Because treatments for ADHD do not help mania, these children with mania are sometimes subjected to an unproductive parade of therapies for ADHD: multiple drug therapies, psychotherapies, and family therapies. The outcome can be disaster as the untreated bipolar disorder leads to drug abuse and other complications.

Some clinicians will also resist diagnosing bipolar disorder be-

cause they discount symptoms of mania due to circumstances in the child's life. The child's parents may have been recently divorced (or remarried); the family may have moved to a new town; he or she may have done poorly in school or not achieved as expected in a sporting event; the family have recently been under financial stress, leading to parental arguments and a chaotic lifestyle. Although it is true that many psychiatric signs and symptoms can be responses to single or persistent stresses, it is also true that some children survive these stresses unscathed while others have problems. Attributing symptoms to stress and not treating them can be dangerous if the child's reaction to these stresses is actually a sign of an underlying disorder. Whether the reaction is a sign of an underlying disorder depends on whether the child meets the other criteria for the disorder, rather than simply exhibiting a mood component response to stress.

To prevent children with mania from reliving the tragedy of Nick Traina's life, some clinicians have discarded the principle of differential diagnosis when dealing with ADHD and mania in children. Instead, if the child meets criteria for both disorders, these clinicians treat both disorders. If the child does have both disorders, the therapies for mania will help with the manic symptoms and the therapies for ADHD will help with the ADHD symptoms. This approach has a crucial advantage that any parent with a child with "severe" ADHD should consider: It potentially short-circuits the havoc that mania wreaks upon children and their families.

In addition to the confusion between ADHD and mania, parents of children with mania need to know about the confusion between conduct disorder and mania. As described earlier, the extreme irritability of children with mania leads to aggressive and destructive outbursts. If you review the symptoms of CD in Chapter 4, you'll see how these outbursts could easily lead to the antisocial behaviors of CD. When this happens, some clinicians will diagnose the child as having CD, not mania. In this case you should use the lesson learned from the discussion of mania and ADHD. Because bipolar disorder is such a severe condition, treating such children as if they had another disorder can have grave consequences. If you suspect that your child has bipolar disorder, I urge you to discuss this with your clinician or to find another doctor willing to consider the possibility that your child suffers from mania.

A Roadmap to Treatment: Bipolar Disorder*

Medicines

1. Novel antipsychotics (e.g., risperidone, olanzapine)
2. Mood stabilizers (e.g., lithium)
3. Anticonvulsants (e.g., carbamazepine, valproic acid, Lamictal)

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Parent management training
3. Collaborative problem solving

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

Chapter 6

Worry and Anxiety

Fear is a necessary ingredient of human experience, alerting us to danger and protecting us from harm. It is such an automatic response that sometimes we aren't even consciously aware of the threat before fear surges through our body, tensing muscles, speeding the heartbeat, greasing our hands with sweat, and flooding our mind with many "fight-or-flight" possibilities. Because it prepares us to defend ourselves or flee a threat to our well-being, it is essential to our very survival.

Unfortunately, fear sometimes oversteps its bounds. In some people fears arise for no reason, out of the blue. Or they arise for good reasons but are much too extreme. One child is terror-stricken at the thought of going to school; another is periodically flooded with panic for no reason at all. A third is so fearful of dogs she cannot play outdoors. Dysfunctional fear screams, "stop, look, listen" at the wrong time, telling us to slow down when we should forge ahead or to escape from a situation we should embrace whole-heartedly.

When most of a child's fears are false alarms, that child has a fear disorder. But the level of fear, the amount of impairment and distress it causes every day, and the objects of the fear must be fairly extreme and unusual for a child to be diagnosed with one of these disorders. After all, it's natural for children to fear the unknown, and the younger they are, the more unknowns their world is likely to hold. Fears of the dark, of the "monster under the bed," of the first day of school, and many other fears are often completely normal.

In judging what is normal fear and what is abnormal, you (and any clinician you consult) also have to take into account that different people experience different amounts of fear. What's normal for one child (or adult) may not be normal for another. You probably know some thrill-seekers, who find excitement where others find fear, such as in roller-coasters and rock climbing, parachuting and bungee jumping. You might also know some worrywarts, people who see danger lurking around every corner. Because they can't stop thinking of the latest air disaster, they're afraid to fly. They're tense in traffic and high-strung in crowds, shy with strangers and timid with friends. They jump at every unexpected sound. We don't necessarily view any of these people as ill. If the degree of impairment caused by their fear is manageable, and the level of fear they feel isn't way out of proportion to the threat, we usually chalk up these differences to "personality" and tolerate them the way we tolerate other personal differences.

But what about those cases when a fear has no obvious physical source? The child who cries and clings when separated from Mother cannot pinpoint a tangible source of his or her worries, though there may be many imagined causes such as fear of being kidnapped. In this case we call the emotional response anxiety rather than fear. When the cause or trigger of the fear—such as a fear of dogs—is obvious, we call it a fear. When the cause or trigger is intangible or imaginary, we call it anxiety. Because fears have a specific physical source, they are usually easy for parents to spot. The child will scream at the sight of a dog, point with fear to dogs on TV, or simply tell his parents he or she does not like the creatures. But the type of fear we call anxiety can be more difficult to spot. When a child becomes distressed every time he or she is dropped him off at preschool, it is usually not clear exactly what the source of distress is. Does the child fear the preschool? The teacher? A schoolmate? Or is it fear of separation?

For you to help your child, it's not necessary to understand all the nuances of the difference between fear and anxiety. But if you have a fearful, nervous, or very shy child, you should try to figure out whether the fear has a specific physical source. You can figure this out by observing your child and listening to him or her talk about the fears. It also helps to ask questions, but don't give your child the third degree. If you feel frustrated that he or she can't pinpoint the source

of the fear, use the information in this chapter (as well as the observation techniques in Chapter 1) to help you figure out what's wrong.

Another frustration faced by parents of anxious children is the difficulty they have communicating with their child about anxiety. Although children develop thinking and language skills at an early age, they require many years of experience to communicate as effectively as adults. One crucial step in the growth of communication skills is the move from concrete to abstract thinking, which is not complete until the teenage years. Before then, children do a good job thinking and talking about concrete events (such as being near a dog). But they find it very difficult to think and talk about abstract events (such as what might happen to them or their parents after separation or how they feel about it).

Because of the child's difficulty expressing abstract fears in language, these abstract fears known as anxiety express themselves in behavior (clinging), observable emotion (crying), and even physical symptoms (stomachaches, nausea, vomiting). The child's expression of anxiety perplexes parents, leading them to more frustration and even anger as they try to figure out what exactly is wrong with their child.

When I met Maurice's parents, Lynn and Ray, they were at their wits' end. Every morning when Lynn dropped Maurice at preschool he would become tearful and sometimes cry uncontrollably. Several times each week the preschool would call Lynn or Ray at work, informing them that Maurice was not feeling well. Sometimes it was a headache, other times nausea. Once he even vomited. Maurice's pediatrician found no physical ailment, so she suggested a mental health evaluation. Having seen many such children before, she was not surprised to learn that Maurice had separation anxiety disorder.

We have learned a lot about anxiety in children in recent decades, and we have many effective treatments. Children with some types of anxiety disorders, especially if the disorders are relatively mild, can often be cured. But these children may retain a tendency toward anxiety throughout life, perhaps because they are biologically predisposed to it. Even when an early anxiety disorder remits, it's not unusual for a different anxiety disorder to emerge later in the child's development. Parents therefore will need to remain alert to the signs of impairment from anxiety as their child grows.

Parents often question whether a child is truly anxious or just under stress. We've become so conscious of the impact of stress in the lives of children as well as adults that we reflexively look for environmental stressors to explain behavior problems and emotional disturbances in our kids. It makes sense to look for such explanations, but not as a substitute for seeking help if your child is suffering. Just as with depression, the presence of an environmental stressor—some unusual pressure or trying event—does not rule out a child's having a diagnosable disorder and needing help. The determining factor must always be whether the child is impaired. In that case, whatever the trigger, the child needs help.

PHOBIAS

What Are Phobias?

A phobia is an excessive, unreasonable fear in response to a specific object or event. Consider the 5-year-old known as Little Hans, a patient of the famous Sigmund Freud, the Austrian psychiatrist who invented psychoanalysis. Little Hans was, by all accounts, a normal boy until one day while walking in the street he felt extremely fearful. At first his parents thought he feared being outside or perhaps in the street. But eventually they realized that the source of his fear was horses, which were common on the streets of Austria at the time.

Hans's fear of horses became unreasonable. He refused to leave his home, and, even in the protection of his bedroom, he feared that a horse might hurt him. There was one obvious cause for his fear—one day, while out for a walk in the street, he had been frightened by the fall of a big, heavy horse and the chaos it caused. But his fear of horses persisted far beyond that one event and created serious problems for him and his family as it became more and more difficult for him to leave their home.

The case of Little Hans highlights four main features of all phobias. His fear of horses was excessive, unreasonable, persistent, and disabling. Remember, fear is normal if it comes in the right dose. Phobias are too much of a good thing. Phobias are excessive. Most small children would be cautious near a large animal. Depending on their age, they might run to a parent or, at least, move out of the ani-

mal's path. But they wouldn't flee in terror or scream for help. They would experience just enough fear to keep them safe.

Phobias are unreasonable. They simply don't make sense. When the child is asked why he is afraid, he cannot give you a sensible reason. As a result, you cannot use logic to persuade him to stop being afraid. Little Hans's father probably explained that horses were well trained and well behaved and that they rarely hurt people. He probably reminded Hans that they both had encountered many horses in the past and that these encounters had been uneventful. But trying to talk someone out of a phobia is fruitless and frustrating. Phobias flow not from a cool stream of thought but from a volcano of emotion.

FAST FACTS about Phobias

1. A disorder of unreasonable, persistent, disabling fears
2. Diagnosed in about 5% of children
3. More common in girls than boys
4. Can start in childhood or adolescence
5. Usually caused by a traumatic event

Phobias are persistent. The parents of Little Hans did not call Dr. Freud at the first sign of their son's fear of horses. They worried about Hans only after they realized that his extreme, unreasonable fear of horses would not abate. Most children show unreasonable fears of some sort at some time in their lives. In fact, there is a normal developmental progression of fear in young children. Fear of strangers can be intense in the first year of life but dissipates at older ages. From the ages of 1–5 years, children will fear separation from parents, loud noises, animals, and darkness. With age, normal fears become more complex and are more likely to be linked to social situations. Between ages 6 and 12 children will fear failure, punishment, discipline in school, and bodily injury. Adolescents will be more likely to get nervous before tests and will be easily embarrassed in some social situations.

Phobias are disabling. Because most children experience some fear, it is easy for parents to be confused about the fears they see in

their children. How do you know when a child's fear is a normal phase of development or a psychological problem? The answer lies in the degree to which a fear disables the child. When fears become disabling, they warrant the attention of mental health professionals. We describe a fear as disabling if it interferes with the child's normal routine. Although today a fear of horses would not be much of a liability, 19th-century Austrians had to deal with horses on a daily basis. For Little Hans, a fear of horses was as problematic as a fear of cars would be today. Phobias disable children in many ways. These fears interfere with learning at school and make them seem foolish to friends. The child wastes much time anticipating feared situations and may struggle with lingering doubts and unpleasant emotions long after the feared event is over.

Consider two children I've known who were afraid of dogs. When he was 5, Henry would cling to his mother when they walked past a dog. If he visited a friend who had a dog, the dog would have to be chained or locked in a pen. I did not think Henry had a serious problem for two reasons. Fear of dogs is fairly common among 5-year-olds, and he didn't show any extreme reactions that led to problems in his daily life. But I was very worried about Bruce, who at the age of 14 had been extremely fearful of dogs for over a decade. The mere thought of a dog would make him nervous. Encounters with dogs usually led him to have panic attacks. Because of this fear, his mother had to drive him to school, he rarely would venture outside alone, and he refused to visit friends who owned dogs. Bruce had a persistent, unreasonable fear that was excessive for his developmental level and interfered with normal living. He needed help.

Table 6.1 gives the specific criteria mental health professionals use to diagnose phobias. These criteria require phobias to be excessive, unreasonable, persistent, and disabling fears. They also give clear behavioral criteria that will help you figure out if your child's fear is truly a phobia. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) defines a persistent fear as one that bothers the child for at least 6 months. During this time period the child must frequently show distress when faced with the feared object or avoidance of the feared object. The avoidance criterion is especially important. Many people with phobias experience little fear because they have learned how to avoid the feared object or situation. For example, one child with phobias was brought to my at-

TABLE 6.1. Behaviors Leading to the DSM-IV Diagnosis of Phobia

The child experiences all of the following for at least 6 months:
Persistent fear that is excessive or unreasonable and is triggered by a specific object or situation
Severe fear, expressed in children as panic, crying, tantrums, freezing, or clinging, following almost all exposures to the specific object or situation
Avoidance of the specific object or situation or endurance of it with intense fear or panic
Interference with the child's normal routine, school functioning, social activities, or relationships or severe distress caused by the fear

Note. The symptoms cannot be accounted for by another disorder. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

tention because her mother was concerned that her daughter, Alice, was not making friends at school. She thought that Alice had poor self-esteem and needed psychotherapy. It turned out that Alice was phobic of other people's homes. Because of this she would avoid visiting peers when invited, which made it difficult to build friendships.

Although almost any object or event can be the object of a phobia, some phobias are more common than others. Examples of common phobic objects are dogs, spiders, bridges, and blood. Examples of common phobic activities are being in high places, swimming, being in closed-in places, flying, public speaking, attending social gatherings, and performing in front of others.

Fears of public speaking or social gatherings are examples of what we call social phobia. Children with social phobia can be severely limited. Being fearful around other children, they may not develop normal friendships or participate fully in school activities. They decline invitations to parties, don't attend dances, and don't join athletic teams. Over time they become more and more socially isolated. Children with social phobia are extremely self-conscious. They exaggerate their mistakes. During a soccer match, as they dwell on a misplaced kick, they lose their focus and their play worsens. When they speak during a classroom discussion they stammer and sputter or sit in silence as they discount their own ideas as dull and dim-witted. In their mind, other people see them as clumsy, inarticulate, and boring. Social situations become painful humiliations.

Although there are some superficial similarities, social phobia is not the same thing as shyness. Shy children are quiet and timid around others, but they don't feel the extreme levels of fear that make children with social phobia avoid social situations as much as possible. Shy children, in fact, may enjoy being around others even if they don't participate. Curiously, many children with social phobia are not shy. This is especially true when their social phobia is limited to specific situations such as speaking in front of groups or participating in athletic events. In other settings they socialize with ease and enjoy the company of others.

What Does the Future Hold for Children with Phobias?

Fortunately, most childhood phobias are treatable, and some simply do not endure beyond childhood. In fact, one study that reexamined children with phobias 2 years after their initial diagnosis found that 80% of these children no longer showed phobic symptoms. Although this study did not clarify whether loss of symptoms was due to treatment or simply the passage of time, it does show that many phobias will not be a long-term concern.

We do, however, need to be concerned about the 20% of children who continue to have symptoms. These children may experience several possible outcomes. Many who seek professional treatment will eventually be cured or show a large reduction in their symptoms. For others, their phobia will be a continual bother, perhaps affecting them through adolescence into adulthood. In some cases the phobia will be easy to manage because the feared object can be avoided or is rarely present. For example, one child could never overcome a severe spider phobia. But this presented only a small problem because spiders were not commonly encountered in her urban environment.

Some phobic children will progress to more serious disorders such as panic disorder, agoraphobia, or generalized anxiety disorder. I discuss these disorders in detail later in this chapter. There are no simple guidelines for figuring out which children will worsen. But as a general rule of thumb those who worsen will have more severe phobias, possibly multiple phobias, will meet the criteria for other disorders, and will be more severely impaired by their phobias, such as missing school and losing friends. The three main points for parents are: (1) Don't worry too much about childhood fears. Don't assume

they are a sign of something more serious. (2) Seek professional treatment if a phobia persists and interferes with your child's life. (3) Be on the lookout for a worsening of your child's condition.

A Roadmap to Treatment: Phobias*

Medicines

1. Medicines used for other anxiety disorders and depression, depending on the nature and severity of symptoms
2. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline) for social phobias

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Systematic desensitization
3. Cognitive behavioral therapy (for social phobias)

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

SEPARATION ANXIETY DISORDER

What Is Separation Anxiety?

If you've ever had to leave your child at a day-care center or preschool, you know that young children usually become upset and fearful when separated from their parents. I remember one teacher's vivid report of a particular morning's drop-off. Jake was refusing to enter the class, despite the insistence of his father; Ann—crying uncontrollably—was clinging tightly to her mother; Patty was trying to prevent her father from leaving; and Clyde was sulking at the window, watching his mom vanish into the morning traffic. These were normal children experiencing normal levels of fear and distress after being separated from their parents. All of them (eventually) learned

to be apart from their parents as they grew accustomed to the preschool setting. But many parents find it difficult to accept this behavior as normal because it disrupts classrooms, shakes up parents, and seems very unpleasant for the child.

FAST FACTS about Separation Anxiety Disorder

1. Excessive fear about being separated from the home or from those to whom the child is attached
2. Diagnosed in about 4% of children
3. Equally common in girls and boys
4. Usually starts in early childhood

While these consequences are undeniable, remember that the impact of symptoms is not the only factor that determines whether a problem is a true disorder. Such signs of distress are so common among young children that to interpret them as illness would mean classifying many children as psychologically disturbed. For most kids, anxiety over separation fades as the child matures, a fact that makes many parents more comfortable when subsequent children behave the same way. Also, the behavior is actually adaptive for young children. Fear of separation protects them from straying from their parents and getting lost; it may be a vestigial survival instinct that once protected children from leaving the cave and being killed by predators.

A problem arises, obviously, when separation fears become too strong or persist at older ages, in which case they might indicate the presence of separation anxiety disorder. Having other kids for comparison might help you get an inkling of whether your child's problem is severe enough to have him or her evaluated for the disorder. A veteran preschool teacher can often provide valuable perspective. The difference between normal separation anxiety and the disorder lies in the persistence of the condition and its intensity. Kids with separation anxiety disorder show signs of it throughout each day and exhibit lots of distress—crying, having trouble sleeping, having nightmares, and suffering from stomachaches, headaches, and other physical symptoms.

Table 6.2 gives DSM-IV criteria for separation anxiety disorder. As you read these, understand that the term *attachment figures* usually refers to parents but more generally means anyone with whom the child has developed a strong bond (of the sort usually reserved for parents). This is particularly relevant for children raised by people other than their parents.

The term *developmentally appropriate* means, as you've seen throughout this book, that some judgment must be made about the degree to which the child's behavior is appropriate for his or her age group. This is one of the main tasks of mental health professionals, but for your part the best approach is to compare your child with other children of the same age. In some cases this is

TABLE 6.2. Behaviors Leading to the DSM-IV Diagnosis of Separation Anxiety Disorder

Developmentally inappropriate and excessive anxiety about being separated from the home or from those to whom the child is attached shown by three or more of the following for at least 4 weeks:
Recurrent excessive distress when separation from home or attachment figures occurs or is anticipated
Persistent and excessive worry about losing or about harm befalling attachment figures
Persistent and excessive worry that a harmful event, such as getting lost or being kidnapped, will lead to separation from attachment figure
Persistent reluctance or refusal to go to school or elsewhere because of fear of separation
Persistent or excessive fear or reluctance to be alone or without attachment figures at home or without significant adults in other settings
Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
Repeated nightmares involving the theme of separation
Repeated complaints of physical symptoms (like backaches, headaches, stomachaches, nausea, or vomiting) when separation from attachment figures occurs or is anticipated

Note. The symptoms cannot be accounted for by another disorder. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

easy. For example, a teacher may say something like "I've never seen a 6-year-old get so upset about being away from her mom." In others it will be less clear. But in all cases you can take some guidance from the two main themes of the separation anxiety disorder: The separation fears must be persistent and excessive. Children with true separation anxiety disorder almost always have problems separating from parents, and their reactions are usually severe. They don't simply say they're unhappy; they cry, scream, cling, run out of the classroom, and so forth.

If your child has a true separation anxiety disorder, you will see his or her separation fears in more than one setting. In the first grade, Eric was extremely fearful about being left at school, to the point where his father had to bring him in each day and wait at the back of the class until Eric settled down. But Eric had no problem separating from his parents at other times. When left with a baby-sitter or with friends, he played happily and did not fuss when his parents departed. I suspected that Eric had a specific problem in school and later found that his fear of school was due to a difficult relationship with his first grade teacher. Once that was addressed, he was able to ride the bus to school, waving cheerfully to his parents as the bus departed.

Another sign of true separation anxiety disorder is that the child fears something harmful will happen to him or her or his or her parents if they become separated. For example, one child feared her mother would become ill. Another thought the train carrying his dad to work would crash. Still another feared abduction by a stranger during the school's outside play period. (Note that obsessive preoccupation with such ideas may be a sign of obsessive–compulsive disorder; see Chapter 9). Other children don't express such thoughts but instead have nightmares with similar themes. In some cases, the separation fear is so strong it causes physical symptoms such as stomachaches, headaches, nausea, and vomiting.

What Does the Future Hold for Children with Separation Anxiety Disorder?

Even children who have diagnosable separation anxiety disorder rather than normal separation anxiety often outgrow it. In fact, one

study examined children 4 years after diagnosis and found nearly all of them doing well.

As I've already stated, anxiety disorders emerge in many different forms, and there is no one progressive path that any child can be expected to follow. That is, if the child has a predisposition to anxiety, it may surface as a variety of disorders. In a small minority of cases, separation anxiety is the first sign of a more serious anxiety disorder. Although you shouldn't worry too much about this possibility, being on the lookout for symptoms of other disorders will allow you to get early treatment for your child should he or she be at risk for another disorder.

A Roadmap to Treatment: Separation Anxiety Disorder*

Medicines

1. Benzodiazepines (e.g., lorazepam, alprazolam, clonazepam)
2. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline)
3. Tricyclic antidepressants (e.g., desipramine, nortriptyline, imipramine)
4. Buspirone

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Parent management training
4. Relaxation training

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

PANIC DISORDER

What Is Panic Disorder?

Children with panic disorder suffer short episodes of fierce terror called *panic attacks.* These attacks seem to come out of nowhere. During these attacks they experience a surge of physical symptoms like difficulty breathing, dizziness, chest pain, and a racing heart. The attacks may bring irrational thoughts that some terrible event is lurking in the immediate future. The sufferer may feel certain that he or she is going to die or "go crazy." There is no obvious reason for the attack and, when asked, the child has no explanation.

Panic attacks come repeatedly and without warning. They usually last for several seconds but may endure for several minutes. After this initial attack ends, sufferers may feel tense and jittery for an hour or more. Gradually the symptoms fade away and emotional calm returns.

FAST FACTS about Panic Disorder

1. A disorder of recurring, unpredictable panic attacks
2. Diagnosed in less than 1% of children
3. Equally common in girls and boys
4. Can start in childhood or adolescence
5. Often seen together with agoraphobia

In some cases, the panic attack is obvious to the child's parents. The child may freeze, cling tightly, and complain about the attack's physical symptoms. The physical symptoms often terrify parents, who, worried the child might be seriously ill, rush off to the family physician. In other cases, the panic attack is less obvious. It may come and go quickly, giving the parent little time to observe its effects. Many children who have these attacks are not able to clearly describe their symptoms. They might, for example, complain that they have a bellyache or simply say that they feel sick.

Table 6.3 lists the symptoms of panic attacks within the criteria

for diagnosing panic disorder. Only 4 of the 13 symptoms are required for an attack to be present. We use the work *attack* because the symptoms develop very quickly, reach peak intensity within 10 minutes, and then dissipate. Between panic attacks, the child does not experience these symptoms. It is the "attack" nature of these symptoms that is so frightening to panicky patients and their parents. Even more disconcerting, the initial attacks often come out of the blue, having no clear cause. Later attacks are sometimes triggered by specific objects or situations leading to phobia.

TABLE 6.3. Behaviors Leading to the DSM-IV Diagnosis of Panic Disorder

Recurrent panic attacks, each characterized as a discrete period of intense fear in which four or more of the following symptoms develop quickly and reach their peak of intensity within 10 minutes:

- Heart palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensation of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or stomach upset
- Dizziness, unsteadiness, lightheadedness or faintness
- Feelings of unreality or being detached from oneself
- Fear of losing control or going crazy
- Fear of dying
- Numbness or tingling sensations
- Chills or hot flashes

One or more of the following after at least one panic attack:

- Persistent worry about having another attack
- Worry about what will happen from the last attack (such as dying, or "going crazy")
- A major change in behavior

Note. The symptoms cannot be accounted for by drugs or a medical condition. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

To put it simply, panic attacks become panic disorder when they begin to overwhelm the child and affect his or her daily life. If your child has panic disorder, it is crucial that you understand how severe the symptoms are. Panic is not simply a matter of being a bit nervous or jittery. It is a feeling of sheer terror. You can get some idea of how intensely physical panic attacks are from this fact: Many adults who endure these attacks immediately head for a hospital emergency room. Their symptoms are so intense that they believe they are having a heart attack or some other life-threatening medical emergency.

Because of its intense physical symptoms, parents often treat a child's first panic attacks as a physical disorder. Consulting the child's physician is time well spent. It is essential that physicians rule out medical causes for your child's symptoms. If the search for a physical illness fails, you should seek a comprehensive mental health evaluation for your child.

Panic attacks harm the psychological health of children in obvious ways. When assaulted by panic, your child is momentarily disabled. He or she cannot focus on schoolwork, play well with friends, do chores at home, or complete homework assignments. After the attack, it may take an hour or more for your child to get back on track. Even worse, if the attack occurs around other children, he or she may feel humiliated.

Unfortunately, the effects of panic reach far beyond the short span of the panic attack. A child who has had one attack is naturally very fearful of having another. Although this fear of fear may begin as a passing thought, it often grows into an uncontrollable obsession. He or she decides that avoiding the location of past attacks will protect him or her from future ones. This restricts activities and makes the child very nervous if he or she is forced to be in that situation, as would be the case if one of the attacks had occurred in the school classroom.

Some children will have panic attacks at night. From a sound sleep they wake up with a jolt, heart racing and short of breath. They may scream as if they've had a bad nightmare. Having had one panic attack at night, a child becomes nervous about sleep. This makes it difficult to fall asleep or stay asleep. After a while, this lack of normal sleep makes the child irritable and mentally dull, which adds friction to relationships and impairs schoolwork.

A Roadmap to Treatment: Panic Disorder*

Medicines

1. Benzodiazepines (e.g., lorazepam, alprazolam, clonazepam)
2. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline)
3. Atypical antidepressants (e.g., bupropion, venlafaxine)
4. Tricyclic antidepressants (e.g., desipramine, nortriptyline, imipramine)
5. Buspirone

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Relaxation training

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

What Does the Future Hold for Children with Panic Disorder?

Although some children who have had one panic attack never have another, most continue to have attacks, and if not treated their problem worsens, causing much suffering. Parents of children with panic disorder should be on the lookout for several serious complications: depression and agoraphobia and, for older children, alcohol or drug use. Fortunately, doctors have effective treatments for panic disorder (described briefly later and detailed in Chapter 11), which help affected children live normal lives.

When teens with panic disorder try alcohol or drugs, they quickly learn that some of these substances reduce panic symptoms and calm the fear of fear that pervades their lives. If so, they may be-

gin to use these substances regularly and may become addicted, leading to the substance use disorders described in Chapter 4.

Many children with panic disorder become clinically depressed later in life. There are at least two pathways leading these children to depression. In some cases, the depression is the child's reaction to his or her difficult circumstances. The effects of panic disorder may be so disabling that the child becomes demoralized and depression ensues. But research also suggests that there is an unknown biological link between panic disorder and depression. It seems that the causes of panic and those of depression are, to some extent, the same. So, some children have both sets of causes and develop both disorders.

AGORAPHOBIA

What Is Agoraphobia?

Shelly was diagnosed with panic disorder at age 13 after having had several attacks since the age of 10. Shelly's first attack happened while she and her dad were at the movie theater. The attack was short but fierce, making her drop her popcorn and grab for the security of her father. Her family consulted her pediatrician, who ran a standard battery of tests. During the next 6 months, Shelly had two attacks, one at the local shopping mail, the other in the school cafeteria. After the attack in the cafeteria, Shelly would feel queasy around lunchtime and not eat the sandwiches and treats packed by her father. A week later she asked the teacher if she could study in the classroom instead of having lunch.

FAST FACTS about Agoraphobia

1. Fear about being in situations from which escape might be difficult or embarrassing or in which help may not be available in the event of having a panic attack
2. Diagnosed in less than 1% of children
3. Equally common in girls and boys
4. Can start in childhood or adolescence
5. Often seen together with panic disorder

Concerned about Shelly's eating habits, the teacher called home to explain the situation to her parents. As they talked about this latest development, Shelly's parents wondered if her problems in the cafeteria might be linked to the strange attacks she was having, which the pediatrician could not explain. Then her father realized that Shelly's behavior had changed in other ways. She usually loved to go shopping at the mall but hadn't done so for many months. He also realized that she had stopped asking him to take her to the movies.

After describing this situation to the pediatrician, Shelly was sent for a mental health evaluation. Her psychologist diagnosed her with panic disorder. He also saw that Shelly was at the beginning stages of agoraphobia. Her panic attacks had caused her to develop phobias to three specific locations. As a result, she feared these locations and would avoid them at all costs. Shelly needed treatment. Otherwise her agoraphobia would progress with each new panic attack. If she had attacks at the grocery store, her friend's house, the soccer field, and elsewhere, she would be afraid of so many places she'd have no place to go. That, in fact, is what happens in severe cases of agoraphobia. The person is so paralyzed with fear of so many places that he or she cannot leave home. Or, if he or she leaves home, the person with agoraphobia goes only to a few places where he or she feels safe from panic attacks.

It should be clear from Shelly's story that panic disorder with agoraphobia can be a very disabling condition. Not only must Shelly cope with massive attacks of fear, her phobias prevent her from activities that once had been a source of enjoyment. Fortunately, Shelly was treated successfully, so she is once again able to enjoy a wide range of activities. But if her parents had not sought treatment, Shelly would have lost friendships, seen her schoolwork decline, and, most likely, gotten into conflicts with her parents.

Table 6.4 gives the three defining criteria for agoraphobia. Agoraphobia, especially in its initial phases, can seem much like other phobias because the child is, at first, fearful of only one or two situations or places. The difference between agoraphobia and other phobias is the concern that the child with agoraphobia feels about being able to escape from many different types of situations. For example, a child who has a phobia of driving across bridges will be distressed on bridges and try to avoid them because he or she is afraid the car is go-

ing to fall off. The child with the phobia is afraid of falling off the bridge; the child with agoraphobia will fear the panic attack that he or she may have on the bridge. Another sign that a fearful child is agoraphobic is in the nature of his or her fears, which will all focus on situations outside the home—for example, being in crowds, standing in line, driving across bridges, or traveling in general. When the child with a phobia is afraid of a situation, it is often due to the situation's social context. The child with agoraphobia, by contrast, always fears the inability to escape.

Although agoraphobia can be caused by a preexisting panic disorder, it can also develop in the absence of panic attacks. This pathway to agoraphobia occurs in children who first have one or two phobias and then develop many phobias. Often, their initial phobias include fear of crowds or of closed spaces. Such phobias quickly place many limits on activities since both crowds and closed spaces occur in many locations.

What Does the Future Hold for Children with Agoraphobia?

Regardless of which pathway—panic disorder or phobias—leads a child to agoraphobia, the outlook is poor in the absence of treatment. The trajectory that kids with agoraphobia may follow is similar to that

TABLE 6.4. Behaviors Leading to the DSM-IV Diagnosis of Agoraphobia

All three of the following, in many situations:
Fear about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of a panic attack
Avoidance of the situations, endurance of them with severe distress or with intense worry about having a panic attack, or the ability to confront them only in the presence of a companion.
Avoidance is not better accounted for by another anxiety disorder.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

of panic disorder, except that the fear of so many situations greatly restricts normal levels of activity for an agoraphobic child. As a result, friendships suffer, school attendance falls, and the child with agoraphobia becomes more and more isolated as he or she withdraws from the normal activities of everyday life.

A Roadmap to Treatment: Agoraphobia*

Medicines

1. Benzodiazepines (e.g., lorazepam, alprazolam, clonazepam)
2. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline)
3. Atypical antidepressants (e.g., bupropion, venlafaxine)
4. Tricyclic antidepressants (e.g., desipramine, nortriptyline, imipramine)
5. Buspirone

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Systematic desensitization

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

POSTTRAUMATIC STRESS DISORDER

What Is Posttraumatic Stress Disorder?

As the title of the 1981 bestseller reminds us, bad things can happen to good people. Some of these people are children: A car wreck kills their father, a drive-by shooting leaves them crippled, an earthquake

pins them under concrete rubble, a sex offender assaults them in the park. The list of lurking catastrophes that can cause trauma to a child is far too long. In addition, however, trauma can occur from distant events that the child learns about from the television or from overheard parental discussions. After the terrorist attacks of September 11, 2001, we are all familiar with the distant, indirect experience of trauma. You can use your own personal experience of this collective trauma to try to imagine how it might be for children, who cannot understand or rationalize these events, who wonder and worry about the safety of a parent who travels on business, who hear their parents discussing, in serious tones, the latest news report or editorial speculation.

When catastrophes strike, they leave emotionally crippled people in their wake. It's easy to understand why some individuals are physically crippled from assaults to their body. But the mental effects of trauma can be equally devastating. Some traumatized children will relive their trauma as a recurring movie flickering on the screen of mind, waking them with screams of terror, torturing them on the playground, making them cringe in fear, run for cover, lash out in anger.

FAST FACTS about Posttraumatic Stress Disorder

1. A disorder of recurrent distress caused by exposure to a traumatic event
2. About 30% of children may experience trauma, but only 1–19% of these will experience PTSD.
3. Girls may be more susceptible than boys to effects of trauma.
4. Can occur in childhood or adolescence
5. Can begin years after exposure to the traumatic event
6. Commonly associated with depression

These children have posttraumatic stress disorder, or PTSD. As the name indicates, PTSD is a disorder that occurs after some stressful event. I don't mean the stress from a difficult math test or from being rejected by a girlfriend. I mean, in the words of DSM-IV, an

event that involved actual or threatened death or serious injury to self or others or one that led to intense fear, helplessness, or horror. In children this may be expressed as disorganized or agitated behavior. You may be familiar with PTSD as the "shellshock" that afflicts many combat veterans. Unfortunately, it afflicts many other people, including children who have experienced traumatic events.

Children with PTSD have recurrent scary thoughts and memories of a serious trauma. Sometimes they feel numb to all emotions, even with parents and friends. They cannot feel the warmth of parental love, the mirth of youthful exuberance, or the natural sadness from the death of a pet. But they are nervous, easily startled, and frequently depressed. Some are extremely irritable. Others progress to violence. Fortunately, many of these problems can be avoided if the traumatized child receives appropriate psychological and medical therapies.

At the age of 13, Carla survived a car accident that killed her mother and left Carla with horrible memories of her mother's dying moments. Shortly thereafter, Carla began to show signs of PTSD. She would lie awake until 3 A.M. and sleep until the afternoon. Loud noises startled her and she began to suffer panic attacks. She would avoid traveling by car and could not be left home alone without having constant phone contact with her father. Sometimes, during the day, she felt she was reexperiencing the accident. Due to her PTSD symptoms, Carla missed many days of school, her grades dropped, and she was held back a grade for poor academic performance. At the same time, because she began to spend less time with friends, her social relationships deteriorated.

Understandably, children with PTSD avoid seeing or hearing about things that remind them of the trauma they experienced. When faced with sights or sounds linked to their trauma, they may panic, burst out crying, or explode in a tantrum. The anniversary of the traumatic event may be an especially difficult day.

Perhaps the most frightening symptom of PTSD is the flashback. It may last a moment, a minute, hours, or days. During a flashback the child with PTSD relives the sensory experience of the trauma. He hears the sounds, sees the sights, smells the smells, and senses the feelings felt when the event occurred. Although flashbacks sometimes arrive as disorganized fragments of the original experience, fre-

quently they are so realistic that the child believes the traumatic experience is happening again.

Parents may find clearly agitated behavior like Carla's understandable. But disorganized behavior can be very perplexing. Kids who manifest this behavior go from one thing to the other without a clear focus on the normal sequencing of events in life; their normal routines are disrupted. They may seem out of control and unpredictable. They are exhibiting a clear change from their previous mode of behavior and routine, but parents might not have any idea why. In this case it's important to consult a professional.

Trauma does not always lead to PTSD. For example, many combat veterans from the Vietnam war were able to live normal lives after they returned to the United States. As you might expect, the more serious the trauma, the more likely it is that a child will develop PTSD and the more likely that PTSD will persist and interfere with life tasks. For example, PTSD will emerge in nearly all children who witness a parent's homicide and three of four who witness a school shooting. But this is only a rule of thumb, not a certainty. Some children are extremely resilient and will not be affected by even severe trauma. Differences in resilience explain why, although many concentration camp survivors have long-standing PTSD symptoms, others do not. For unknown reasons, people vary in the degree to which they are vulnerable to the effects of traumatic stress.

But the experience of Vietnam veterans also showed that PTSD can be delayed. In some cases the symptoms do not emerge until many years after the traumatic experience. The possibility of delayed PTSD unnerves many parents, but if you use your knowledge of PTSD symptoms to recognize it if and when it does emerge, you'll be able to find early treatment for your child and thereby lessen the impact of the disorder.

When you're considering whether or not your child has been traumatized, be sure not to underestimate the degree of stress experienced by your child. Remember that your objective view of the possible trauma is not the same as the child's subjective experience. In fact, one study showed that parents tend to underestimate the amount of stress their children experienced from adverse events. Another study of children and teenagers injured in traffic accidents showed that one in four suffered symptoms of PTSD, but only half of those with symptoms received professional help. Their parents sim-

ply did not recognize their psychological problems. This problem occurs when the parent focuses on the nature of the adverse event rather than the child's response in terms of behavior and symptoms.

For example, many parents view mild or moderate injuries from bicycle or car accidents as not causing much stress to children. Yet, research shows that 60% of children who are so injured will have symptoms of PTSD 1 month after the accident. Forty percent will continue to have symptoms 6 months later. For example, while chasing a ball into traffic, 8-year-old Janie was hit by a slow-moving car. Fortunately, she suffered only minor bumps and bruises. But although she suffered little pain and her injuries quickly healed, she was haunted by the accident's memory for many months, would awaken with terrifying nightmares, and was so nervous about the incident that she would avoid walking down the street where she had been hit.

There are good reasons why some parents overlook PTSD symptoms in their children. Many of these symptoms are most easily recognized by the verbal description given by the child. He or she has to describe the nightmares, the distressing recollections, the feeling of being detached from others. Young children do not always have the language skills needed to express their inner thoughts and feelings. So what they say may not accurately reflect what they are thinking and feeling.

Rather than verbal descriptions, young children are more likely to express PTSD as generalized fears of strangers or situations. They will have nightmares and difficulty sleeping and be preoccupied with words, symbols, or pictures related to the trauma. Some children will repeat parts of their traumatic experience in games with real or imaginary friends or in their drawings. A child who survived a tornado that leveled his town might invent a game of "tornado" that replays the events and feelings that occurred during the disaster. For some children, the most notable effect is the loss of a previously acquired developmental skill. For example, one 4-year-old girl, who had been toilet trained for 2 years, lost that skill 1 month after breaking her arm in a bicycle accident.

School-age children are more able to use verbal descriptions, but their parents should be on the lookout for the signs of PTSD listed in Table 6.5. Sometimes the distress of talking about a traumatic event is seen not in the words of emotion used by adults but in a trembling

voice, an inability to recall events, or the mis-sequencing of events surrounding the trauma. In addition to showing distress when exposed to events that are reminiscent of the traumatic event, some children will come to believe that an unrelated warning sign predicted the trauma. When this occurs, the child believes that by paying attention, he or she will see the next warning signs and avoid future traumas. This can lead to much anxiety and apprehension, especially if the warning sign is a common event such as seeing a white car.

So if your child has experienced a traumatic event, pay attention to all of his or her psychological, emotional, and behavioral responses. Listen to your child's verbal descriptions of thoughts and feelings, but also look for other signs and symptoms. And remember this one key point. It's normal to have some psychological problems after a trauma. You should be concerned if your child's problems persist and interfere with his or her life.

What Does the Future Hold for Traumatized Children?

Some children with PTSD will experience a gradual reduction in their symptoms over a few months. Having a supportive and stable family life helps this process but is not a guarantee that PTSD will go away. When PTSD symptoms do not diminish, they can, if untreated, persist for many years.

If left untreated, PTSD can also worsen over time. Common complications include depression and, in older children, use of alcohol and drugs. If depression occurs soon after the trauma, it may signal that PTSD symptoms will persist for a while. Children with persistent PTSD can become very impulsive. As I described in the section about ADHD, impulsivity or "acting without thinking" hurts relationships with friends, increases the risk for using alcohol and drugs, and sometimes leads to legal problems. Their risky behavior can lead to unprotected sex, further accidents, and even death. If PTSD continues into adulthood, its symptoms interfere with stable employment and make marriage difficult to attain or maintain.

The potential for these adverse outcomes should spur parents to seek treatment for their children. It should not dampen your hopes for a full recovery. Consider the case of Monica Seles, who in 1993

TABLE 6.5. Behaviors Leading to the DSM-IV Diagnosis of Posttraumatic Stress Disorder

1. The person was exposed to a traumatic event that included both of the following:
   - The event involved actual or threatened death or serious injury to self or others
   - The person responded with intense fear, helplessness, or horror. In children this may be expressed as disorganized behavior—behavior that isn't planful or goal directed—or agitated behavior.
2. The traumatic event is persistently reexperienced in one or more of the following ways:
   - Recurrent, distressing recollections or, in children, play involving themes of the trauma
   - Recurrent distressing dreams or, in children, nightmares without recognizable content
   - Acting or feeling as if the event were recurring
   - Intense psychological distress when exposed to thoughts or events that remind the person of the traumatic event
   - Physiological reactivity when exposed to thoughts or events that remind the person of the traumatic event
3. Persistent avoidance of things or events that remind the person of the traumatic event and a numbing of responsiveness as shown by at least three of the following:
   - Efforts to avoid thoughts, feelings, or conversations about the trauma
   - Efforts to avoid activities, places, or people that bring on memories of the trauma
   - Inability to recall an important aspect of the trauma
   - Markedly diminished interest or participation in activities
   - Feeling of detachment from others
   - Restricted range of emotions
   - Sense of a shortened future
4. Persistent symptoms of increased arousal shown by at least two of the following:
   - Difficulty falling or staying asleep
   - Irritability or outbursts of anger
   - Difficulty concentrating
   - Hypervigilance
   - Exaggerated startle response

Note. The duration of symptoms must be at least 1 month. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

was the number-one female tennis player in the world. In April of that year, Ms. Seles was winning a tennis match when, during a break, an irate spectator stabbed her with a knife. Although painful, the injury was not life threatening. It healed much more quickly than the emotional wound of the psychological trauma.

For more than 2 years, the tennis world waited for Ms. Seles. Then, in July 1995, after overcoming the psychological and emotional pain caused by the stabbing, she returned to rebuild her tennis career. Her triumph at the 1996 Australian Open proved to the world that, although the road to recovery can be difficult, victims can triumph over trauma.

A Roadmap to Treatment: Posttraumatic Stress Disorder*

Medicines

1. Medicines used for other anxiety disorders and depression, depending on the nature and severity of symptoms

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Systematic desensitization

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

GENERALIZED ANXIETY DISORDER

What Is Generalized Anxiety Disorder?

So far, you've learned about five different problems involving fear and anxiety. As you've been reading about these problems, you may

have asked yourself, "What about the child who just plain worries all the time?" Well, now it's time to discuss that child. He or she may have generalized anxiety disorder (GAD).

Most children worry about something some of the time. That's not a problem. It is only when a child begins to worry about many things most of the time that parents should be concerned about GAD. Children with GAD are constant worriers. They're keyed up most of the time. They seem unable to relax. When a worry comes into their head, it just won't go away. They may have two or three worries that won't go away, or they may shift from one worry to another over a period of time. Children with GAD can worry about almost anything: grades in school, how well they are dressed, comments from friends, being late for school, having a pimple, not being attractive, being too fat, and so forth. If your child worries now and then, that's fine. If he or she is worrying more days than not, your child may have a problem.

FAST FACTS about Generalized Anxiety Disorder

1. A disorder of excessive anxiety or worry
2. Seen in about five percent of children
3. More common in girls, especially in adolescence
4. Can occur in childhood or adolescence
5. Commonly associated with depression

Before her 12th birthday, Sandra had lived a normal life. She did well in school, enjoyed soccer, and had many friends. But gradually she became troubled by many things. She would fret about upcoming tests, even though she always did well. She found it hard to sleep before soccer games, certain that she would make a mistake. Her friendships began to suffer as she became a high-strung companion, chattering about possible problems that never occurred. She was so wired with anxiety that, during the day, she found it difficult to concentrate. Her schoolwork suffered. Although she dutifully respected her bedtime, she'd lie awake, dreading the events of the coming day.

Sandra's worries differed from normal worries in several ways.

They were persistent and frequent and always exaggerated. The facts never seemed to justify her degree of worry. The normal worrier plans for a bad outcome that might actually happen. The GAD worrier plans for disasters when none are on the horizon. Sometimes the child with GAD cannot even pinpoint the cause of his or her worry. The child is simply nervous for no reason at all and can't shake it off, even when he or she knows there's no good reason to be worried. When these worries intensify, the child with GAD gets physical symptoms like trembling, nausea, fatigue, twitching, muscle tension, headaches, stomachaches, and sweating. Because of these symptoms, GAD is sometimes first noticed by the child's pediatrician after repeated testing fails to unearth a physical cause for the child's physical complaints.

Maybe your child is a little shy, is constantly worried about schoolwork and other achievements, talks about these worries a lot, and seems to be concerned about his or her friends not liking him too. Naturally, you don't want your child to go through life worrying, but what can you do? Ask yourself how long this pattern has been going on. Is it getting in the way of his or her childhood life at all? Is he or she getting good grades and making friends? Does he or she have any of the other criteria in Table 6.6?

What's the difference, you may wonder, between a child with many phobias and one with GAD? The answer is summed up in one word—avoidance. The child with a phobia avoids the feared object or event. The child with GAD worries about it but does not avoid it. The child with a dog phobia will walk three blocks out of his or her way to avoid the neighbor's dog, even when it's tied up. The child with GAD will walk right past the neighbor's house but will worry about the dog before, during, and after walking by it. Because of this difference, life of a child with GAD life is less restricted than the life of a child who has many phobias or agoraphobia.

What Does the Future Hold for Children with Generalized Anxiety Disorder?

If it is not treated, GAD can become a persistent, disabling disorder. We know this from studies of adults with GAD. One study of 40-year-

TABLE 6.6. Behaviors Leading to the DSM-IV Diagnosis of Generalized Anxiety Disorder

1. Excessive anxiety and worrying occurring more often than not for at least 6 months. The focus of concern is more than one event or activity.
2. The person cannot easily control the anxiety or worrying.
3. Three or more of the following occur, some more often than not for 6 months (only one item is required for children):
   - Restlessness or feeling keyed up or on edge
   - Being easily fatigued
   - Difficulty concentrating or mind going blank
   - Irritability
   - Muscle tension
   - Difficulty falling asleep, staying asleep or restless unsatisfying sleep
4. The focus of the worry is not another disorder
5. The problem causes distress or impairment in school, friendships, work, or other areas.
6. The problem is not due to drug or alcohol abuse, a medical condition. It does not occur only along with a mood, psychotic, or pervasive developmental disorder.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

old GAD patients showed they averaged a 20-year history of the disorder. About half of them had had GAD since childhood.

When GAD persists, the severity of its symptoms will wax and wane, although some will usually be evident most of the time. Like many psychological problems, these symptoms will worsen with stress. Without treatment, long symptom-free periods are unusual.

When GAD persists past childhood into adulthood, sufferers will have difficulty with relationships and will be impaired at work. In fact, some GAD adults have such severe symptoms that they will cease work and require public assistance. These problems are worsened by the complications of GAD, which include depression, alcohol or drug abuse, and other anxiety disorders.

A Roadmap to Treatment: Generalized Anxiety Disorder*

Medicines

1. Benzodiazepines (e.g., lorazepam, alprazolam, clonazepam)

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Relaxation training
3. Cognitive-behavioral therapy
4. Interpersonal therapy

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

Chapter 7

Learning Disorders

Perhaps the most amazing feature of psychological life is our ability to learn. Children learn to crawl, walk, and run without much assistance from parents. Without explicit instruction, they learn language at an early age. Hearing their parents and siblings speak is all they need to eventually begin talking on their own. At these early ages, for most kids, learning seems effortless, almost automatic.

But as life progresses, learning becomes more complex. In school, the child needs teachers to learn reading, writing, and arithmetic. Learning is no longer automatic, but with good teaching and persistent study most children will learn the three Rs along with other school subjects. Some children do very well in all their subjects; others do very poorly. Most fall in between. Like any other skill, such as hitting a baseball, there are normal differences among children in their ability to learn.

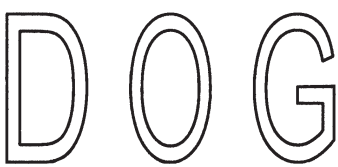
When children do poorly in all subjects, however, teachers and parents are rightfully concerned. The child who fails in school may have a difficult time succeeding in life, especially in a culture such as our own, which values academic ability and requires intellectual skills for many jobs. These children may be mentally retarded, a term that refers to a variety of conditions that lead to low intelligence and difficulty learning in school.

Parents and teachers should also be concerned when a child seems to be relatively intelligent in many ways but struggles mightily in one subject, such as math, or with one particular skill, such as reading comprehension. We all have academic strengths and weak-

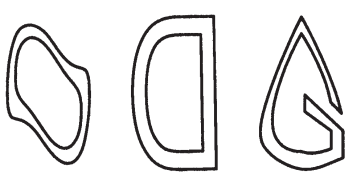
nesses, and most adults can remember doing much better in one subject compared to others. But when the difficulty is extreme or so fundamental that it affects the most basic learning, a learning disability should be suspected and investigated.

Learning problems challenge parents and teachers because they are not usually cut and dried. A child doesn't always have obvious problems in a single area. Sometimes the problem has a pervasive effect on the child's learning across all subjects. If the child has a high intelligence level, a learning disability may not cause him or her to fail but certainly may keep the child from achieving what he or she is capable of achieving—now and in adulthood.

A learning disability also may masquerade as something else. If you're among the fortunate majority of people, you easily read and understand this word:



No problem. With little effort you've read, understood, and probably drawn a mental picture of man's best friend. But imagine if the word you just read looked like this instead:



This one's a puzzle. Is it scrambled dog? Or something else? Imagine if words always looked scrambled, if you had to learn to read books of scrambled words. This demand places a great deal of stress on a child with even a prodigious intellect. Many kids who are forced to deal with this handicap day after day in school understandably act

out. Sometimes their disruptive behavior gets the teacher's and parents' attention, and no one realizes that it's just the child's reaction to the stress of trying to learn with a disability. Just as likely, the child's emotional equanimity can be affected by the stress of living with a learning disability. Trying so hard and continually failing can make a child irritable, frustrated, dejected, or angry. Again, the child's apparent moodiness might divert attention from the underlying learning problem.

Eight-year-old Nguyen is an example of a child who almost fell through the cracks because his learning disability went undetected for 2 years. Nguyen is a bright little boy who soaked up knowledge like a sponge when his parents read to him or talked to him or he watched an educational program on TV. From his very first day in preschool, teachers loved his ebullient personality, model classroom behavior, and attention to detail. Everyone envisioned a bright academic future for Nguyen—until he was asked to learn to read in first grade. At that point he struggled with reading, was in the lowest reading group, and wasn't interested in reading at home. At first his parents just thought he wasn't a stellar student and was interested in different things. According to his optometrist, Nguyen had normal vision. Yet when he looked at words the letters seem all mixed up. Words just didn't make sense. If you met Nguyen, you'd never know he had a reading disability unless you asked him to read or write a simple sentence. But, even though the school psychologist said Nguyen was more intelligent than most of his classmates, his learning disability frustrated his first-grade teacher's best efforts.

Fortunately, Nguyen's second-grade teacher had the benefit of better training in the area of reading disabilities, and after her first month she strongly suspected that Nguyen's reading problems were associated with a disability, especially since he was above average in math and his other subjects. The school psychologist tested him and concluded that he probably had a learning disability. Nguyen's school has given him access to a reading specialist who has done a thorough diagnosis and understands his style of learning. The reading specialist helped his teacher develop accommodations in the classroom to facilitate his learning overall and specifically spent a few hours each week with him on learning to read. Nguyen's reading has improved, but the specialist and his teacher still think it could be better. Instead

of being the second-worst reader in the class, he is now just a little below average.

FAST FACTS about Learning Disorders

1. A disorder of lower-than-expected school achievement
2. Found in about 5% of children
3. More common in boys
4. Can occur in childhood or adolescence
5. Not due to lack of opportunity, low intelligence, poor teaching, impaired senses, or cultural factors

Nguyen's story highlights two key features of learning disabilities. First, his reading ability is not only very low; it is much lower than we would expect from his abilities in other subjects and his high level of intelligence. He is not mentally retarded; in fact he is fairly bright. Children with learning disabilities can have varying levels of intelligence; the determining factor is whether their performance in a specific area of learning is much worse than we would expect from their general level of intelligence.

It took Nguyen's parents some time to learn the second key feature of learning disabilities. For several months they assumed, because their son was so bright, that he must not be trying very hard in school. He also seemed to be goofing off at home, ignoring the simple notes they left on the kitchen board where everyone's chores for the day were posted. But Nguyen was not lazy, bored, oppositional, or careless. He was trying as hard as he could. Learning disabilities are not caused by disruptive behavior, nervousness, moodiness, or plain sloth, though children with learning disabilities can have other psychological problems, and in fact are more likely to have them than other children.

The most common learning disabilities are those that interfere with the three main subjects mastered in school: reading, writing, and arithmetic. Children with disabilities in these skills are usually many years behind their classmates in achievement. Reading disorders are also known as dyslexia. Because reading is an exceedingly

complex process, there are many types of reading disabilities. Some children, like Nguyen, see scrambled words. Others see words normally but cannot easily string together the sounds of individual letters to form the entire word. They can repeat the word *dog,* but when they see the letters *d-o-g* written out, they cannot merge these three sounds into the word *dog.* Other children see normal words and can pronounce them but cannot understand. Reading also requires children to understand grammar, scan words on a page in the correct sequence, store words and ideas in memory, and connect the meanings of words in sentences with each other and with other sentences. Breakdowns in these or other processes can lead to reading disabilities.

Some children read and speak normally but cannot express themselves well with written language. Developmental writing disorders can be limited to severe spelling problems. They can also involve poor composition due to an inability to master written grammar or to clearly express ideas in writing.

'Rithmetic, the third R of elementary school, can be the most difficult disability to deal with. Math is a multifaceted discipline, requiring many different types of mental abilities, any of which can be disrupted by a learning disorder. To quickly and correctly solve arithmetic problems, children must be able to recognize numbers and mathematical symbols. They must master the concepts behind the symbols and have the memory skills needed to recall multiplication tables and mathematical rules. The complex mathematical problems faced in higher grades require logical reasoning skills that can be impaired in some children despite their having simple arithmetic skills.

In recognition of the fact that learning disabilities can interfere severely with children's ability to exercise their right to public education, learning disabilities are defined not only in the diagnostic manual (see Table 7.1) but also in federal law. Both definitions define children as learning disabled if there is a significant discrepancy between their overall level of intelligence and their skills in a specific area. Federal law and some state laws mandate certain provisions to help children overcome learning disabilities in public schools. See Chapter 12 for more information on special education and the law.

From the preceding definition it should be clear that not all children with learning problems are learning disabled. For example, a

TABLE 7.1. Behaviors Leading to the DSM-IV Diagnoses of Learning Disorders

The child must experience all three:

1. Achievement in a skill (reading, arithmetic or writing) is much less than expected for the child's age, intelligence, and level of education
2. The problem interferes with other areas of achievement or activities of daily living that require the skill.
3. The achievement problem is not due to impaired senses.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

mentally retarded sixth grader who reads at the first-grade level does not have a learning disability. He is reading as well as we would expect from his low level of intelligence. In contrast, a highly intelligent sixth grader reading at the sixth-grade level might very well have a learning disability if his or her level of intelligence leads everyone to believe this student should be reading at the eighth-grade level.

As you have seen in other chapters, the diagnosis of most psychological problems relies on verbal reports from children, parents, and teachers about the signs and symptoms that define each problem. But to diagnose learning disabilities, we need more than someone's impression of how intelligent the child is and how well he or she is doing in school. We need the results of standard tests, usually completed by a school psychologist and a speech and language specialist. These tests are described more fully in Chapters 10 and 12.

The psychologist's tests will yield a number that measures the child's intelligence, called the intelligence quotient (IQ), and other numbers that measure how well he or she is doing in specific academic areas such as reading and mathematics. By comparing the child's IQ with his or her performance on tests of academic skills, the psychologist can determine whether the child has a learning disability. The tests given by the speech and language specialist will test the

child's pronunciation, vocabulary, grammar, and sensory abilities to see if these might account for the learning problems.

Other specialists such as audiologists, neurologists, or psychiatrists may also be called in as needed. It is very important for your child to be checked for simple sensory problems. Defects in vision and hearing can impair learning and thereby mimic learning disabilities. If identified and corrected early, they can save children a lifetime of struggle and humiliation.

Because speech and language are essential for learning, problems in these areas usually impede efficient learning. They are not considered learning disabilities per se but are treated as a separate category of disorders. Speech problems take many forms. Some children cannot form certain sounds, others speak at a very slow or fast rate, and others mix up similar sounds. Professionals call such problems developmental articulation disorders. Often they are outgrown or treated successfully with speech therapy, but they can persist and cause serious language difficulties.

Some children have no problems making speech sounds to form words, but they have problems either expressing their thoughts through speech or understanding spoken language. Some children understand what they are told and learn to read but, even though they can make sounds and mold them into words, they have a tough time stringing words into sentences to make meaningful conversation. These children have expressive language disabilities. They find it difficult to use words to express their thoughts. These problems come in many forms. For example, some of these children struggle to find the right word. They speak slowly, with a halting cadence, but can string words into sentences and express complex ideas. Others can easily choose the right word but cannot speak in sentences longer than three or four words.

Other children can express themselves well. They build sentences from words and send them off with ease. But when language is spoken to them, they don't understand. These children have receptive language disabilities. They can use words to express their thoughts, but they find it difficult to understand others. Some of these children cannot understand specific words. But despite this problem in understanding, they might be able to understand these words when written and they may be able to repeat them when

heard. Other children find it difficult to understand complex sentences. They may have no problem understanding words or short sentences, but longer sentences bewilder them.

What Does the Future Hold for Children with Learning Disorders?

Have you ever traveled in a foreign country where you did not speak the language and few people spoke English? In that setting, simple tasks become chores. The traveler stranded in an airport searches blindly for a rest room, unable to read the many signs that direct native speakers. Keeping up with news back home is impossible unless you can find a copy of the *International Herald Tribune* or a usually out-of-date copy of an American newspaper. With some effort and much consultation with a guidebook you figure out the bus system yet still end up lost from time to time.

If you've had such an experience, you may have an inkling of what it's like to have a learning disability. People with learning disabilities struggle with street signs, instructions, newspapers, making change, and writing checks. They're supposed to understand their native language or use simple math skills. But they cannot. As you might imagine, not being able to read, perform simple math skills, or communicate easily serves up a daily diet of frustration and failure. For children with learning disabilities, school is not simply a challenge. It's a thankless chore. So it's no surprise that 4 in 10 children with learning disabilities drop out of school.

Learning disabilities are the most harmful when they are not recognized at an early age. Because they are not recognized, they are not treated. The child then falls further and further behind, which will make it more difficult to attain normal levels of achievement in the future. For example, the child who does not learn word recognition will never read sentences. Those who do not learn sentences will never read paragraphs. The unrecognized learning disability will erode a child's self-esteem. The child begins to view him- or herself as slow or stupid. Teasing by peers may further lower the child's sense of self-worth. As he or she becomes more and more alienated from mainstream peers, the child may turn to delinquency or drugs.

The unrecognized learning disability also taxes the emotional resources of the family. Tensions may grow in the household as parents

become frustrated helping with homework. If they see their child as lazy instead of as having a learning disability, that will lead to hostile exchanges and family stress. Some parents become guilt-ridden and depressed about their inability to help their child learn. Others may engage in well-meaning but stressful, unproductive battles with school personnel. The cumulative stress on the family can place parents at risk for marital problems.

In this day and age, any developed country has the tools for identifying all its children with learning disabilities. For the most part, teachers and school officials do a fine job of screening for and identifying learning disabilities. But mistakes still occur and some learning disabled children are not identified. There are four main ways in which this could happen.

It's easy to miss a learning disability in children who have above-average intelligence. For example, Nelson was at the top of his fourth-grade class in every subject except reading, which was average. Because he could read at the fourth-grade level his teachers did not consider him to have a reading problem. Yet, because his reading ability was much lower than we would expect from his high intelligence, they should have suspected a learning disability. Children like Nelson often do fine during their first years of school. Because of their high intelligence, they can compensate for their with learning disability. But in later years, as problems get harder and assignments get more complex, the learning disability emerges. The late emergence of a learning disability puzzles parents and teachers. Because the child never had such problems before, they may be slow to even consider that the child has a learning disability.

Some children with learning disabilities are missed because teachers misinterpret their poor performance as a sign of low general intelligence rather than a specific disability. This is especially problematic for children of low intelligence. All their failings are attributed to their being "slow." Although they may indeed be less intelligent than the average student, it is still possible for them to have a learning disability. Deciding whether a child is "slow" or has a learning disability is not a simple matter. It requires extensive psychoeducational testing, again, usually by a school psychologist.

Sometimes deficient academic skills are identified but, instead of being attributed to a learning disability, they are attributed to other causes: poor motivation, chaotic homes, or other problems such as

attention-deficit/hyperactivity disorder, conduct disorder, or anxiety. You may have heard a teacher say something along the lines of "Johnny could read fine if he would only try" or " . . . if his parents would be of more help" or " . . . if he would only pay attention" or " . . . if he wasn't so badly behaved." The main problem with this type of thinking is that it cannot explain why Johnny does well in his other subjects.

Although it is possible that an apparent learning disability is due to other causes, you should be wary about accepting such an interpretation. It's much more likely that your child has a true learning disability, which requires remedial attention. Sometimes teachers and school officials will attribute your child's learning problems to another psychiatric problem. Because psychiatric disorders affect behavior, emotions and thinking, they can interfere with learning.

We know from research studies that many learning disabled children have one or more other problems, including ADHD, conduct disorder, oppositional disorder, depression, or an anxiety disorder. If your child does have another disorder, you should ask your doctor to help you figure out if the other disorder is causing his or her learning problems. But whatever the doctor concludes, you should not ignore a learning problem. Instead, you should seek treatment for both the learning disability and the other disorder.

Sadly, there is also a shameful bureaucratic reason why some children with learning disabilities are not identified. As you will learn in Chapter 12, schools are required by federal law to provide special services to all children with learning disabilities. Although the federal government requires that these children receive services, it does not provide the funds to hire the teachers and resources that schools need to help them. Instead, the federal law requires local school districts to provide whatever funds are needed to treat children with learning disabilities.

Unfortunately, many school districts do not have sufficient funds to help all of the children with learning disabilities that they should serve. These financial limitations mean that schools can only identify as many children with learning disabilities as they can afford to serve. In practice, this usually means that the most seriously impaired children are recognized as having a learning disability. Milder cases are not, even though they could benefit from special services.

Despite these possibilities, parents of children with learning dis-

abilities should know that there is much hope for many of them. Some will "grow out" of their learning disability as they get older and their brain develops. These children have experienced what psychologists call "maturational lag." The growth of specific brain regions is slower than normal, which leads to specific learning problems until brain development is completed. Moreover, educators and psychologists have developed helpful remedial programs for children with learning disabilities. As a result, the outlook for these children is more hopeful than it had been. Those with relatively mild disabilities can often overcome their disability and develop sufficient skills for surviving in the world, despite some continuing problems such as difficulties in organizing books, notes and documents or in managing time. Although they will learn to read for information, they may never read for enjoyment.

Other children never fully overcome their disability but can learn to compensate. For example, a child with a severe reading disability might enter a trade that requires little reading. If the child goes to college, he or she may make extensive use of tape-recorded materials or hire "readers" to read aloud for him. Overcoming a learning disability is challenging but not impossible.

If there is one fact that children with learning disorders and their parents should remember, it is this: A learning disorder is like a physical handicap. It impairs one part of the learning process but spares others. Just as a child who cannot walk can use a wheelchair to move about, so too can children with learning disorders work around their disabilities to function normally. Nelson Rockefeller served as governor of New York for four terms. He had a learning disorder. Albert Einstein could not talk until the age of 4. His teachers described him as mentally slow. He failed his college entrance exams yet changed the world we live in with his theory of relativity, which won him the esteem of peers and *Time* magazine's award for Man of the Century.

Einstein probably had a learning disorder. It was wrong for teachers to describe him as "mentally slow," as wrong as it is now for anyone to describe any learning disordered child in such terms. By painting such a grim picture of their abilities, teachers and parents can, without meaning it, destroy a love of learning and prevent a child with a children with learning disability from great achievements.

A Roadmap to Treatment: Learning Disorders*

Medicines

1. No specific pharmacological treatment for learning disorders. Treatment for co-occurring disorders may improve behavior and attention in school.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Individualized Education Program at school (see Chapter 12)

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

Chapter 8

Abnormal Development

Most of us would give our children the world if we could. But when asked to be more realistic, all we really wish for them is a good chance at growing into healthy, strong, happy adults. That's why pervasive developmental disorders can be so heartbreaking. Having a pervasive developmental disorder (PDD) means lagging behind in the mental, emotional, social, and athletic skills that are required for maturation into well-adjusted adults and facing a raft of problems as a result. A diagnosis of PDD challenges the deepest hopes we have for our children.

Fortunately, the past decades of research have taught us a lot about the major PDDs—autism, Asperger syndrome, Rett's disorder, and childhood disintegrative disorder. The future for many children with these disorders has never been brighter. We are still far from understanding why these disorders occur, but we have made significant strides in helping many children with PDD adapt so that as adults they can function in ways we once thought impossible, including, in the best cases, working, living independently, and even marrying.

Which children with PDDs may be able to achieve these milestones depends on many variables, including not only how severe the disorder is in the child but also when and how accurately the child is diagnosed, what kind of treatment is provided, how soon it is implemented, and how long it is continued. The best outcomes for autistic children seem to result from early and intensive intervention with therapy that teaches the child social skills and capitalizes on the

unique strengths that many children with autism spectrum disorders have—especially those who are considered "high-functioning."

The trouble is, however, that public attention has often been diverted away from developments in treatment and trained instead on news about the latest discovery about the cause of autism and whatever "miracle" cure is inferred from that supposed cause. In this chapter I will give it to you straight: what we know about PDDs and how much we don't know, how to sort out the signs and symptoms of these baffling disorders, and what you might expect for your child. In some cases it is difficult to determine exactly which PDD a child has—especially when comparing Asperger syndrome with high-functioning autism—so in the following pages I'll discuss what each disorder looks like separately.

Probably more than any other class of psychiatric disorders, PDDs have been blamed on bad parenting. For many years, doctors blamed the parenting practices of cold and distant "refrigerator mothers" for causing autism in their children. We now know that parenting style or skill has nothing to do with a child's having autism or any other PDD. There is evidence that genes create a predisposition to autism, and we know from brain imaging and autopsy studies that structural anomalies can be found in the brains of people with autism. The problem is that these abnormalities vary widely from person to person, leaving us with little certainty about what causes the disorder. Genetic studies suggest that autistic symptoms are inherited in widely varying forms and degrees. This may mean that parents or other relatives of children with autism could show a wide range of behaviors associated with autism but manifested in such different ways as to be unrecognizable and much too mild to be considered a disorder.

AUTISM

Autism is a serious, impairing disorder that emerges early, during the first 3 years of life. Fortunately it is rare. Only 1 in 500 children will be affected. Although at one time it was believed that autism was more likely to be seen in families with highly educated or financially successful parents, we now know this is not true.

All autistic children show severely abnormal development in social interaction and communication along with a restricted range of

(and sometimes repetitive) activities and interests. But because these problems can be expressed in many different ways, two autistic children can look very different from one another.

In her first year of life, Carolyn differed from other infants. Most infants enjoy interacting with their parents, responding to sights and sounds, and exploring their environment. But Carolyn sat motionless in her crib, ignoring her parents, her toys, and even the sounds of wind chimes in her room. She disliked being touched or cuddled, responding to affection with tears or pulling away. Like most parents of autistic children, Carolyn's parents were devastated by her behavior. They felt rejected and wondered if they had done something wrong.

With age, Carolyn's problems worsened. She showed an unusual pattern of development. She stood up before she crawled and, by 30 months old, was still not talking. To communicate, she grabbed things or screamed. As a young child, Carolyn was obsessed with keeping things in order. She would line up shoes in her closet, straighten chairs around the dinner table, and always put her bathroom supplies (soap, toothbrush, toothpaste, hairbrush) in exactly the same place. If someone moved them, even 1 inch, she would throw a temper tantrum her parents could not control.

By the age of 4 she had learned enough language to speak very simple sentences. She rarely tried to communicate with her parents or other children. Every now and then Carolyn would become aggressive, sometimes for no apparent reason. Suddenly she would throw toys, smash windows, or kick the family cat. Her behavior made it so hard for her parents to care for her that, at age 8, they placed her in a program where she receives 24-hour supervision.

FAST FACTS about Autistic Disorder

1. A disorder of abnormal development in social interaction and communication along with a restricted range of activities and interests
2. A rare disorder found in about 1 in 500 children
3. More common in boys
4. Starts before age 3
5. Often associated with very low intelligence

Unlike Carolyn, Fred was playful and affectionate as an infant. A firstborn child, he was the daily joy of his parents. Like most new parents, they were elated when he could sit up and crawl, and they were amazed at how quickly he learned to walk, speak, and count. For the first 1½ years of his life, Fred was developing into a normal boy. But at that age, his parents began to notice some unusual behaviors. One day his dad found him sitting alone in his bedroom, repeatedly pushing a toy car back and forth along a 3-inch stretch of carpet. He seemed oddly absorbed in this movement, continuing for 15 minutes. He would not respond to his name when called. He simply pushed the car. When his father grabbed the car away from him to get his attention, Fred began to scream with uncontrollable rage. From that day on, Fred was a changed child. He lost his affectionate nature and did not care to play with his parents or even be in the same room with them, preferring the isolation of his bedroom and the strange solace afforded by his toy car. He sometimes bit himself or picked at his skin until he bled. He would sometimes, without warning, throw things or yell at his parents. Eventually, his language skills worsened. He seemed unable to use words as clearly as he had a year earlier. At this time, his parents sought help and learned that he had autism.

Although Carolyn and Fred had different patterns of development, they both had autism. Both had the three main features of autism that are listed in Table 8.1: impaired social interaction, impaired communication, and signs of restricted, repetitive, and stereotyped behavior, behavior consisting of harmful or nonfunctional movements that seem driven by an internal force and repeat themselves over and over. Examples are waving, self-biting, body rocking, head banging, mouthing of objects, picking at skin, or hitting one's own body.

From the first year of life, most humans are intensely social beings. An infant will gaze at her parents, turn her head toward voices, grasp at fingers, and eventually smile and respond to smiles. Most young children quickly learn that there is a special give-and-take quality, or reciprocity, in social relations. When their parents smile, they smile back. A friend says "hi" from across the street, and they return the greeting. In contrast, autistic children never seem to understand the give-and-take of social interaction. As infants, they avoid contact with parents and may never smile, either on their own or in

TABLE 8.1. Behaviors Leading to the DSM-IV Diagnosis of Autistic Disorder

1. Six or more of the following. At least two from group (a) and one each from (b) and (c)
   a. Signs of impaired social interaction:
      - Marked impairment in use of nonverbal behaviors like eye contact and gestures
      - Failure to develop friendships
      - Failure to seek to share enjoyment, interests, or achievements with others
      - Lack of social or emotional reciprocity
   b. Signs of impaired communication:
      - Delay in, or lack of, spoken language
      - If speech is present, impaired ability to initiate or sustain conversation
      - Stereotyped, repetitive, or idiosyncratic use of language
      - Lack of varied, spontaneous make-believe or social imitative play
   c. Signs of restricted, repetitive, and stereotyped behavior, interests, and activities:
      - Preoccupation with stereotyped and restricted patterns of interest that are abnormal in intensity or focus
      - Inflexible adherence to nonfunctional routines or rituals
      - Stereotyped and repetitive body movements
      - Persistent preoccupation with parts of objects
2. Before the age of 3, delays or abnormal functioning in at least one of the following:
   a. Social interaction
   b. Language used in social communication
   c. Symbolic or imaginative play
3. The disturbance must not be due to Rett's disorder or childhood disintegrative disorder.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

response to another. Like Fred, most autistic children seem to prefer spending time alone rather than with their parents or other children, even if this means being alone in their room, doing nothing at all. They neither panic when parents leave nor show pleasure when they return. They resist affection, cannot cuddle, and show minimal responses to parental emotions.

Most children are naturally curious about other children and will seek their company if only to play side by side in the same room. Autistic children are indifferent. Lacking this natural curiosity, they ignore their peers and have few real friendships. When they are with others, they do not understand how to interact using behaviors such as gestures, eye contact, facial expressions, and body movements. Sometimes they will show a modified version of the normal behavior. For example, they might maintain brief eye contact or use peripheral vision when speaking with others.

Often, autistic children do not respond with appropriate emotions. For example, one day a schoolmate of Fred's told him sadly that his cat had died. Fred grinned a silly grin and poked the child in the belly. Not only did Fred misunderstand the verbal content of what was said; he did not connect with the emotional state of the other child. He simply did not understand the subtle facial expressions and vocal changes that tell us when someone is not happy. As you might expect, for Fred, winks, grimaces, smiles, and stares convey little meaning. When his mother calls "Fred," the meaning to him is the same whether she is yelling while she stares in consternation or gently cooing while smiling broadly. Even if Fred responds, he uses an all-purpose, robotlike voice that expresses no emotion or reaction. For Fred and other autistic children, the social nature of the world makes little sense.

In normal children, language development follows a predictable pattern. Infants begin communicating by babbling nonsense syllables. They eventually form these into "Mama," "Dada," and other simple words. Eventually they string words into sentences, and the magic of language development takes flight. But this magic eludes the autistic child. About half will never utter a meaningful word even though they may have babbled early in life. Others show some language skills, but these emerge much later than normal and never catch up to the level of their peers. Some will be able to say many words but never speak a full sentence. Others will repeat a stock set of sentences, even if inappropriate for what is happening around them. Some autistic children show echolalia, persistently echoing the words of others. Carolyn would repeat her mother's questions and rarely give a meaningful answer. Fred would irritate his parents by repeating TV commercial jingles.

Autistic problems in communication include not only poor language skills but also the inability to engage others in even simple conversation. With normal development children learn not only the mechanics of language—its words and grammatical forms—but also how to use language for effective conversation. But unlike other children, autistic children cannot easily communicate with others. They have difficulties using spoken language and may communicate with grunts or hand movements.

As we saw in the story of Carolyn, some autistic children direct aggression at objects, other people, or even themselves. This aggression is most likely to occur when they are in a strange place or when they feel overwhelmed or frustrated. We do not understand why this occurs. More commonly, they display signs of restricted and repetitive behavior, interests, and activities. We saw that in the way Fred played with his toy car. His play was restricted to one simple movement, which he repeated over and over again. When the repetitive behavior has no function for communication, play, or some other goal, we describe it as stereotyped behavior. Examples include hand shaking, head banging, and rocking.

Repetition sometimes shows up as inflexible adherence to nonfunctional routines or rituals. We saw this in Carolyn's straightening of chairs and organization of her bathroom supplies. She went through these routines in exactly the same way, every day. If she was interrupted, she would become extremely upset and even aggressive.

Sometimes the autistic child has an intense and persistent preoccupation with parts of objects. When Fred was given a small plush elephant for his second birthday, he became fixated on the animal's right ear. He would not pick up the elephant, but sometimes he would hold or stroke the right ear for more than one hour at a time.

Autistic children often show an unusual sensitivity or lack of sensitivity to sights, sounds, tastes, smells, or texture, although these sensory symptoms are not used by clinicians to make the diagnosis. This can occur in many ways. For example, sometimes almost any sound would make Fred cover his ears, as if the sound was deafening. Carolyn had to wear very smooth clothing because she found the feel of textured or rougher clothes annoying and sometimes painful. Other autistic children seem immune to cold or barely react to what anyone else would consider a painful event (such as breaking an arm

or being seriously cut with a knife). But even these children may show oversensitivity at other times.

Another common feature of autism that is not part of the diagnostic criteria is deficiencies in self-help skills such as getting dressed and performing personal hygiene tasks. This problem is not a separate symptom, though it certainly disables the child significantly. Instead, it is essentially a consequence of stereotyped behavior. A child who is, for example, playing with his or her toothbrush all the time is completely uninterested in and distracted from tasks involved in self-care.

Intelligence shows some contradictory trends in autism. Many autistic children have a low level of intelligence, so low that it interferes with learning and prevents them from attaining the level of skill and independence that would be appropriate for their age. But about 1 in 10 autistic children (regardless of whether they have overall low intelligence) show remarkable intellectual gifts at an early age. They are called *autistic savants.* Some examples of their unusual talents are extraordinary memory, performance of complex mental calculations very quickly (the so-called "lightning calculators"), and knowing which day of the week corresponds to any calendar date in the past or future. You may recall the movie *Mercury Rising,* in which Bruce Willis plays an FBI agent who protects an autistic savant who inadvertently deciphered a top-secret government code. There is also a group of children with what is sometimes called *high-functioning autism*. These kids, as the name implies, are capable, especially with intervention, of functioning more normally in the world than most autistic children. This label does not signify a separate diagnosis but a level of impairment. Most of these children have either mild autism or misdiagnosed Asperger syndrome. Another very rare possibility is that a child with high-functioning autism has been misdiagnosed with autism altogether and is actually just extremely uncommunicative for other reasons.

If your child is showing the signs of autism or has been diagnosed with autism, the disorder is probably affecting your family in a number of ways. Undoubtedly, you have been frustrated by trying vainly to communicate and make emotional connections with your child. Expressing love and affection to a child and receiving nothing in return is central to the heartbreak of autism, and the sadness you feel at being deprived of this most basic joy of parenthood may be im-

measurable. In addition, you must deal with the effect that autism has on your other kids, who must put up with endlessly repetitive communications and behaviors. These problems combined can seem overwhelming, and you may end up wondering in despair, when you ask yourself how your beautiful child could have ended up with such a devastating disability, whether it is in some way your fault. As discussed further later in this chapter, we really don't know what causes autism. What we do know, however, is that parents are not to blame. Like most other psychiatric disorders, autism is a brain disorder that neither the parent nor the autistic child can control.

A Roadmap to Treatment: Autism*

Medicines

1. No specific pharmacological treatment for autism. Treatment for co-occurring disorders may help. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline) may help repetitive behaviors. Beta-blockers, clonidine, lithium, anticonvulsants, or novel antipsychotics (e.g., risperidone, olanzapine) may help with aggression and self-abuse.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Intensive parent management training
3. Multimodal treatment in structured setting, which includes:
   - Special education
   - Speech and language training
   - Teaching self care and social interaction skills
   - Prevocational and vocational training (for higher functioning adolescents)

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

ASPERGER SYNDROME

Asperger syndrome shares many features with autism. Both cause severe and sustained impairment in social interaction, and both include restricted and repetitive patterns of behavior, interests, and activities. But, as shown in Table 8.2, the two disorders differ in one major way. Unlike autistic children, those with Asperger syndrome do not show delays in language, thought, or self-help skills. In addition, children with Asperger syndrome do not have the low intelligence seen in autism, Rett's disorder, and childhood disintegrative disorder. Because of these differences, some people describe Asperger syndrome as mild autism. A child with Asperger syndrome may be capable of going to school, because of relatively normal intelligence and language abilities, as well as relatively normal self-help skills.

FAST FACTS about Asperger Syndrome

1. A disorder of severe and sustained impairment in social interaction with restricted, repetitive patterns of behavior, interests, and activities
2. Rarer than autism, but the true prevalence is unknown
3. May be more common among boys
4. Usually starts before age 9
5. Intelligence is not affected

Although children with Asperger syndrome use language to communicate, their speech shows some abnormalities that are usually related to the social use of language. For example, their voices may be flat and emotionless or stilted and repetitive. They do not seem to understand the normal give-and-take of conversation. As a result, their conversations frequently revolve around themselves or favorite subjects.

Although the criteria state no significant delay in the development of language, the child with Asperger syndrome seems not to truly understand the nuances of language and how language is used to achieve social goals. Although, unlike autistic children, they seek

TABLE 8.2. Behaviors Leading to the DSM-IV Diagnosis of Asperger Syndrome

1. Two of the following signs of impaired social interaction:
   - Marked impairment in use of nonverbal behaviors like eye contact and gestures
   - Failure to develop friendships
   - Failure to seek to share enjoyment, interests, or achievements with others
   - Lack of social or emotional reciprocity
2. One of the following signs of restricted, repetitive, and stereotyped behavior, interests, and activities:
   - Preoccupation with stereotyped and restricted patterns of interest that are abnormal in intensity or focus
   - Inflexible adherence to nonfunctional routines or rituals
   - Stereotyped and repetitive body movements
   - Persistent preoccupation with parts of objects
3. The problems in 1 and 2 lead to impaired functioning at home, in school, or elsewhere
4. No delay in the development of language, thinking, and self-help skills or curiosity about the environment.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

social interaction, they have a hard time doing this with language. For example, most of us take for granted that asking questions is an easy way to get to know someone or to maintain a conversation. This simple fact is lost on most people who have Asperger syndrome.

Although thinking is not impaired, kids with Asperger syndrome can become obsessed with narrow and complex topics, such as weather, mathematics, and astronomy. Their thinking tends to be very concrete, focused on observable details. They are less fluent with abstract ideas. Their memory for details is usually excellent.

The child with Asperger syndrome moves around in a clumsy and uncoordinated manner. These kids are usually very poor at sports, preferring narrow academic pursuits in school. Some may have problems with handwriting or drawing.

Because Asperger syndrome is much milder than autism, it is not as easy for parents or professionals to recognize. One problem is that many children with Asperger syndrome also have another disorder—notably, tic disorders, attention-deficit/hyperactivity disorder, oppositional defiant disorder, and obsessive–compulsive disorder. So do children with the other PDDs, but because Asperger's is a milder condition, there is a greater chance that a co-occurring disorder will obscure the signs of Asperger's, and the child won't be diagnosed with a PDD at all. Another hazard is that Asperger's will be diagnosed when the child actually has autism. Language is cumulative in a developing child, so the severity of a communication deficit may not be evident in the very young. What may be seen as Asperger's because the PDD symptoms seem mild could reveal itself later to be more severe autism as the child skips language milestone after milestone.

A Roadmap to Treatment: Asperger Syndrome*

Medicines

1. No specific pharmacological treatment for Asperger syndrome. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline) may help repetitive behaviors. Treatment for co-occurring disorders may help.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Social skills therapy
4. School accommodations as needed

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

RETT'S DISORDER

Rett's disorder is much rarer than autism—so rare, in fact, that it is difficult to say how many children it affects. For some unknown reason, it has been found only in girls. Like autistic children, those with Rett's disorder have problems with social interaction and language and odd, stereotyped movements. Because of these similarities, Rett's disorder is often confused with autism.

FAST FACTS about Rett's Disorder

1. A disorder of multiple specific deficits following a period of normal functioning
2. Rarer than autism but the true prevalence is unknown
3. Has been seen only in girls
4. Starts before age four, usually at one or two
5. Usually associated with very low intelligence
6. Often associated with epilepsy or bone and joint diseases

But the two disorders are qualitatively different (see Table 8.3). The main distinction between them is in how the disorders progress from birth through early childhood. In autism, problems with development emerge in the first 3 years of life. Whether this occurs gradually or quickly, autistic children continually worsen during the first 3 years of life, and they almost always show some abnormalities within 5 months of being born. In contrast, children with Rett's disorder show completely normal development for the first 5 months of life. Only then do they begin to show signs of the disorder. One of these signs is not seen in autism: In Rett's disorder, head growth slows down between 5 and 48 months of age.

There are other differences between autism and Rett's disorder. The following features are often seen in autism but not in Rett's disorder: frequent play with hard objects, a preference for being alone, rejection of caresses and affectionate touch, hyperactivity, excessive attachment to objects, and repetitive playing habits. In contrast, the

TABLE 8.3. Behaviors Leading to the DSM-IV Diagnosis of Rett's Disorder

1. All of the following:
   - Normal development before and immediately after birth
   - Normal development of movement for 5 months after birth
   - Normal head circumference at birth
2. All of the following occur after the period of normal development:
   - Head growth slows between 5 and 48 months of age.
   - Loss of purposeful hand skills and development of stereotyped hand movements between 5 and 30 months of age
   - Loss of social interaction
   - Poorly coordinated walking or body movements
   - Severe language problems and severe slowing of movement

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

following features are common in Rett's disorder but not autism: slow movements, repetitive washing movements, difficulty chewing, and periodic hyperventilation (excessive breathing that can lead to dizziness and fainting).

A Roadmap to Treatment: Rett's Disorder*

Medicines

1. No specific pharmacological treatment for Rett's Disorder. Treatment for co-occurring disorders may help. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline) may help repetitive behaviors. Beta-blockers, clonidine, lithium, anticonvulsants, or novel antipsychotics (e.g., risperidone, olanzapine) may help with aggression and self-abuse.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Intensive parent management training

3. Multimodal treatment in structured setting, which includes:
   - Special education
   - Speech and language training
   - Teaching self-care and social interaction skills
   - Prevocational and vocational training (for higher functioning adolescents)

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

CHILDHOOD DISINTEGRATIVE DISORDER

Like autism and Rett's disorder, childhood disintegrative disorder causes problems with social interaction and language and odd, stereotyped movements. The primary distinctive feature of children with childhood disintegrative disorder is that they show normal development in all areas for the first 2 years of life (see Table 8.4). But eventually (usually by age 4, definitely by age 10), the child with childhood disintegrative disorder begins to lose previously acquired skills. These lead to abnormalities in language, social interaction, play, movement, and, sometimes, loss of bladder or bowel control.

FAST FACTS about Childhood Disintegrative Disorder

1. A disorder of marked backsliding in many areas of functioning after 2 years of normal development
2. Rarer than autism, but the true prevalence is unknown
3. May be more common among boys
4. Starts before age 10, usually by age 4
5. Usually associated with very low intelligence

The onset of childhood disintegrative disorder can be abrupt or gradual. Sometimes it occurs after some disease such as measles or

TABLE 8.4. Behaviors Leading to the DSM-IV Diagnosis of Childhood Disintegrative Disorder

1. Normal social, communication, language, and play development for the first 2 years of life
2. Serious loss of skill in two of the following areas before age 10:
   - Language
   - Social and self-help skills
   - Bowel or bladder control
   - Play
   - Movement skills
3. Problems in two of the following areas:
   - Social interaction
   - Communication
   - Restricted, repetitive, and stereotyped behavior, interests, and activities

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

encephalitis damages the brain. Other times it emerges on its own, without any prior illness. At first, children with childhood disintegrative disorder become anxious, irritable, overactive, and disobedient. Then they show a downward spiral until they exhibit many of the behaviors seen in autism. Their deterioration is usually swift. Any speech and language skills they had acquired are usually gone within months.

A Roadmap to Treatment: Childhood Disintegrative Disorder*

Medicines

1. No specific pharmacological treatment for childhood disintegrative disorder. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline) may help repetitive behaviors. Treatment for co-occurring disorders may help.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Multimodal treatment in structured setting, which includes:
   - Special education
   - Speech and language training
   - Teaching self-care and social interaction skills
   - Prevocational and vocational training (for higher-functioning adolescents)

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

WHAT DOES THE FUTURE HOLD FOR CHILDREN WITH PERVASIVE DEVELOPMENTAL DISORDERS?

Unfortunately, most PDDs lead to serious lifelong disabilities. There are, however, exceptions to this rule, especially for Asperger syndrome, which does not impair language or intelligence. In fact, some people with Asperger syndrome are very successful and may have brilliant careers. But even then others may view them as eccentric, absent-minded, socially inept, and physically awkward.

For the intelligent person with Asperger syndrome, obsession with detail and preoccupation with narrow subjects can be a real benefit. For example, reviewing pages and pages of a computer program for errors would bore most people. But a person with Asperger syndrome might be delighted by that prospect. People with Asperger syndrome may find a productive niche in structured, detailed fields like accounting, library cataloging, and cartography.

Autistic children usually worsen in adolescence. They become increasingly aggressive and overactive and may lose any simple language skills they have learned. With early intervention, however, these kids have a better chance of maintaining their language skills.

Most cannot live independently, but those with higher intelligence and less severe symptoms will be able to live somewhat independently as adults, such as in group homes. Because autistic people cannot relate well to others, however, their occupational choices are usually limited.

One research study examined grown-up autistic children at the age of 20. None of these young adults were living on their own. Thirty percent were living with their families, and the rest were living in institutions or group homes. Most of the people in institutions or homes had no meaningful speech. Similarly, in 1991 a Swedish follow-up study found that two thirds of patients remained completely dependent on others throughout life. The others achieved varying degrees of independence, but all showed some signs of residual disability, especially as regards social relationships.The best predictors of partial recovery seem to be higher intelligence, some normal speech, and some normal play by the age of 5. Clinical experience confirms these research findings—that children who have some useful language and higher intelligence at age 5 have a better outcome. It also suggests that outcome has improved overall during the past few decades with the application of intensive multimodal treatments in structured settings, which include special education, speech and language training, and teaching of self-care, social, and vocational skills. Generally, mild autism in childhood tends to predict mild autism in young adulthood.

With the exception of rare cases, the life of autistic children will be far from normal. But that does not mean they must live isolated lives of despair behind the walls of some institution. With treatment and support from parents and teachers, many autistic children are able to live at home and attend school. They will usually be in special classes for impaired children. These classes can lead to small (but meaningful) improvements in social, language, and academic skills. As treatment methods for autism improve, we hope that many autistic adults will be able to do meaningful work and participate to some extent in the lives of others.

A small number of adults with autism live on their own and hold simple jobs. Some can drive a car, earn a college degree, and get married. They usually need special job training and some support to help them deal with the daily pressures of work and relationships. Support

groups for adults with autism are also helpful. Although these higher-ability autistic adults have a much milder form of autism than the usual case, they give hope for parents that treatment and support can help their child take small steps toward a more normal life.

One symbol of hope for autistic people and their parents is Dr. Temple Grandin, a middle-aged autistic woman who has had a successful career designing equipment used for livestock. Dr. Grandin holds a PhD in animal science and has written several books. Although her successes are far from typical, her story is worth hearing because it offers hope for all parents of autistic children.

By the age of 6 months, Temple was showing signs of autism. Since childhood, her hearing has been hypersensitive. She feels as if she is wearing a hearing aid that has its volume control on "super loud." Loud noises are painful. Sudden loud noises hurt her ears "like a dentist's drill hitting a nerve." She cannot turn down the volume to a comfortable level, but she can turn it off and tune people out. So as a child she sometimes acted as if she were deaf. Because she cannot fully control the on/off nature of her hearing, sometimes she tunes out the world when she should not. That makes it difficult to follow conversations or lectures. As you might imagine, hypersensitive hearing presents many challenges. Most people can speak on the phone in a noisy office, shopping mall, or bus station. But Dr. Grandin cannot because she cannot screen out the background noise from the telephone conversation.

As a child, Dr. Grandin withdrew from affectionate touch because, to her, it felt unpleasant. Some types of clothing were uncomfortable, making her itch intolerably. She describes misbehaving in church because her Sunday clothes were so irritating. Even as an adult she finds it difficult to adjust to new clothing. They just do not feel comfortable until she's had several days to get used to them.

In contrast to these problems with touch and texture, Dr. Grandin describes enjoying the pressure of a good hug. But for her a good hug required the right level of pressure. When people hugged her, it was usually too intense and overwhelming. So she would stiffen, flinch, and pull away. As a child she found one way to get the right amount of pressure. She would get under sofa cushions and have her sister sit on them. When she was 18 years old, she built a squeezing machine that allowed her to control the duration and

amount of pressure applied to her body. This created the comfort she sought without the overwhelming stimulation.

In early childhood she began to understand others and formulate ideas with language, but she could not speak. The words simply would not come out. Imagine her frustration! She describes thinking to herself that screaming was her only way of telling parents and teachers she did not want something. With the help of a speech therapist, she began to speak some simple words at age 3, but the road to spoken language was arduous.

The pain of overpowering sensations and her frustrations with language led to fits of rage and screaming where she threw and broke things. Sometimes she moved toward the other extreme and would be found sitting quietly for hours, fixated on a single object such as a spinning coin or a pile of sand. Her symptoms were so extreme that her doctor advised that she be sent to an institution for troubled children. But her mother, seeing the outcome of other institutionalized children at that time, enrolled her in a therapeutic program for children having speech impairments. (Today the health community has moved away from long-term institutionalization and toward helping children function as highly as possible in the outside world, and Grandin's mother probably would not have had to take this step to avoid institutionalization.)

Throughout elementary school Grandin's speech was never completely normal, and even as an adult she finds some aspects of conversation difficult. One example she gives is understanding the rhythm of conversation and knowing when it is her turn to speak. For her, sense of rhythm has been a broader problem. Although she has perfect pitch for music and can easily clap out a musical rhythm, she finds it difficult to synchronize with others. Clapping out a rhythm on her own is easy. Doing so in time with others is not.

Dr. Grandin's social life was never normal. Even as a successful professional she realizes that autism makes it difficult for her to fit into social situations. What social life she has is focused on people who are interested, like her, in either livestock or autism. Rather than be with others on a Friday or Saturday night, she prefers reading professional papers or drawing. She prefers reading nonfiction to fiction, and when she does read a novel it is one that focuses on places and their physical description, not on interpersonal relationships.

It is difficult to know exactly why Dr. Grandin was able to re-

cover from autism whereas so many others cannot. It is possible that, as a child, she had a relatively mild case or actually had Asperger syndrome. She highlights two reasons for the gradual improvement she experienced from childhood to adulthood. She found medication treatment to be extremely helpful, which underscores the need for all troubled children to receive appropriate medical care. But she also points to the encouragement and support of mentors throughout her life.

As a young child, she had a speech therapist to help her with language and a governess to provide her with structured play and social activity. Her mother worked closely with these mentors and with teachers to provide the most supportive environment possible for her child. Her high school science teacher noticed in the young Dr. Grandin an unusual and intense interest in some equipment used for livestock. By understanding the nature of this interest he helped her develop it from an autistic fixation to a successful career path. By doing so, a narrow fixated interest was broadened into a wide range of productive activities. Numerous people helped her through college and when she first entered the work force.

Temple Grandin's story has inspired many people with PDDs to test the limits of their potential. It gives hopes to parents that efforts to help autistic children can succeed. While Dr. Grandin's story is the exception rather than the rule, it does offer lessons for those who seek to follow her path. Improving outcome in autism requires a good deal of care from mental health professionals and educators. Speech therapists, physicians, teachers, psychologists, and others can help. Improving outcome also requires mentors. Sometimes the mentor is a parent, sometimes a teacher or professional who takes a special interest. Other times it will be a friend, an employer, or even another autistic person who has attained a successful outcome.

Employers can help autistic people by accommodating to their social interaction problems and providing jobs in areas where their gifts for concentration and creativity are especially useful. Instead of becoming bored and lax with detailed work that many people would find tedious, autism gives them an intense fixation as long as the work suits their particular interests. In general, some autistic people can produce outstanding work if the employer can provide a quiet, stable, and predictable work environment that specifies clear goals and objectives.

Chapter 9

Obsessive–Compulsive Disorder, Tourette's Disorder, and Eating Disorders

The disorders in this chapter are grouped here mainly because they don't fit neatly into any other classification. Obsessive–compulsive disorder is technically an anxiety disorder, but, as you'll see, it is so different from the problems described in Chapter 6 that it is something of an anomaly. Tourette's disorder and obsessive–compulsive disorder often occur in the same families, so we suspect there is a genetic link between the two. Eating disorders largely remain an enigma. We don't know for certain what causes them, and they can be very difficult to treat. What we do know is that they often co-occur with disorders such as depression and anxiety.

OBSESSIVE–COMPULSIVE DISORDER

What Is Obsessive–Compulsive Disorder?

Have you ever had a repetitive thought that you just couldn't get off your mind? Maybe one morning as you started your car, preparing to drive to work, you've had the thought "Did I lock the door to my house?" When the thought returns over and over and over again, we call it an *obsession.* At the core of an obsessive thought is something

to worry about ("I'll be robbed today if the door's not locked"). The obsession is unpleasant, intrusive, and makes you feel very nervous.

When the repetitive thought leads to a repetitive behavior, we call that behavior a *compulsion.* So imagine I'm starting my car and think "Did I lock the door to my house?" I get out of my car to check the door. I see that it's locked and return to my car. As I prepare to leave, I again have the thought "Did I lock the door to my house?" I get out of my car to check the door. I see that it's locked and return to my car. As I prepare to leave, I again have the thought "Did I lock the door to my house?" I get out of my car to check the door. I see that it's locked and return to my car.

This repetitive cycle of thought and behavior is an example of obsessive–compulsive disorder. The basic obsessive–compulsive cycle is (1) an unpleasant thought occurs, (2) the thought makes you afraid, and (3) a specific behavior relieves your fear (but only for a very short while, sometimes minutes or seconds). If this cycle occurred only once, it would be a reasonable reaction to uncertainty. When it repeats itself over and over and over, problems ensue.

FAST FACTS about Obsessive–Compulsive Disorder

1. A disorder of recurring and persistent thoughts and behavior associated with anxiety
2. Diagnosed in about 4% of children
3. More common among boys than girls
4. Can start in childhood or adolescence
5. Is often associated with tics or Tourette's syndrome

Even if the behavior seems like an unreasonable reaction to uncertainty—such as aligning your shoes neatly in your closet because you think something bad will happen if you don't do so—it will not be viewed as a compulsion unless it is repeated over and over, to the point of disrupting normal functioning. People who have obsessive–compulsive disorder end up spending more and more time wrapped up in their obsessions and responding to the anxiety they cause by performing certain rituals—all to the detriment of other obligations,

such as personal hygiene, schoolwork, chores, and socializing. Their obsessions and compulsions can begin to dominate their lives. Table 9.1 gives the criteria doctors use to diagnose the disorder.

One common compulsion is washing. In this case the child cannot stop thinking that he or she or the child's belongings are contaminated by some unknown filth, which will lead to sickness and maybe death—either the child's own or that of someone important to him or her, typically a parent. This makes the child nervous and leads to continual washing. Taken to extremes, kids and adults with this compulsion can end up spending hours washing their hands and perhaps

TABLE 9.1. Behaviors Leading to the DSM-IV Diagnosis of Obsessive–Compulsive Disorder

1. Either obsessions or compulsions:

   Obsessions must include the following:
   a. Recurrent and persistent thoughts, impulses, or images that are intrusive and inappropriate and cause anxiety or distress
   b. Problems in *a* are not simply excessive worries about real-life problems
   c. The person tries to ignore or suppress the thoughts, impulses, or images
   d. The person realizes that his or her mind has produced the thoughts, impulses, or images

   Compulsions must include the following:
   a. Repetitive behaviors or mental acts in response to an obsession or according to rigid rules
   b. The goal of the repetitive behaviors or mental acts is to reduce distress or prevent some dreaded event. They are not realistically connected to the event or are excessive.

2. At some point, the person recognizes that the obsessions or compulsions are excessive or unreasonable (this item is required for adults but not for children).

3. The obsessions or compulsions cause marked distress, are time-consuming, or significantly interfere with normal life.

Note. The symptoms cannot be due to another disorder or be accounted for by drugs or a medical condition. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

also objects they come into contact with often, too, such as furniture and clothing. Even when hours of daily hand washing leave the person's hands chapped and cracked to the point of bleeding, the person with obsessive–compulsive disorder pursues the obsessive–compulsive ritual.

Although, like washing, many compulsions are physical acts, such as checking locks and opening doors or touching other people only when wearing gloves or holding a handkerchief, some are mental acts, such as counting shirts in a closet or repeating a word silently. In these cases, the compulsion isn't visible to others. In some cases this creates the mistaken impression that the child suffers only from obsessions and not compulsions as well.

Most people with obsessive–compulsive disorder can think clearly enough. In fact, the diagnostic criteria require the person with obsessive–compulsive disorder to be aware that the obsessions come from his or her own mind and to try to ignore or suppress them. But kids who can't prevent intrusive thoughts from invading their mind often feel "crazy." Adults with obsessive–compulsive disorder realize that their obsessions make no sense, and many children do, too, especially the older they get. The man who checks the door knows it is locked but still must check. The teenage girl who washes her hands repeatedly knows she is clean but still must wash. People with obsessive–compulsive disorder perform these behaviors not because they make good sense but because they relieve their fears. It's knowing that their fears, along with the rituals they perform to assuage them, make no sense that makes children question their own sanity. Fortunately, doctors can usually assure these kids that it's their awareness of the irrational quality of their obsessions and compulsions that makes them sane.

Kids with obsessive–compulsive disorder in fact often make Herculean effort to hold their symptoms at bay. Because they realize that their behaviors are odd and might arouse criticism from parents, teachers, and others, they often struggle to beat obsessive thoughts out of their mind, and they resist the urge to perform compulsive behavior. If your child is keeping you waiting while he or she spends increasingly longer periods of time hand washing, you may understandably feel impatient and conclude that your child isn't trying very

hard to control his or her behavior. In fact, though, he or she may be expending enormous mental and emotional effort to keep this behavior from imposing on the rest of the family. He or she could be adopting some mental ritual to avoid hand washing some of the time, or he or she could be changing the hand-washing routine so that you don't see ritual being performed all the time. It's important that you stay alert to what your child is going through so that he or she can get the help that is needed. Obsessive–compulsive disorder is not a disorder of defiant behavior; it's not psychosis ("insanity"); and it's not easy to control. It is, however, painful and embarrassing, so much so that many adults hide their disorder and avoid seeking treatment for years. In the case of children, it's your job to identify your child's obsessive–compulsive behavior as a problem deserving professional attention. It's very easy to assume that the child will just drop "these silly fears" once this "phase" has run its course or that the child is just acting out and can be disciplined in a way that will force the child to stop. Unfortunately, the nature of obsessive–compulsive disorder is such that the problem is likely to get worse if left alone, and it's only when the child and family are pretty miserable that many people recognize the need for help.

Obsessive–compulsive disorder can end up tyrannizing an entire family. Young children often involve parents and even siblings in their obsessions and compulsions. Your child could have you spending 45 minutes every evening checking for monsters or locking and relocking every window in the house or washing your clothing five times or setting the table in a very precise order for every meal. Whatever the ritual is, and whether or not you participate directly, obsessive–compulsive disorder can cut drastically into time that would otherwise be devoted to necessary chores and errands, quality time spent with the other children in the family, personal relaxation, and more.

It's usually when the family feels held hostage by obsessive–compulsive disorder that parents seek help. Often they have tried in vain to talk their child out of the obsessions and compulsions, or to use punishments and rewards, pleading or commanding to get the child to stop this disturbing behavior. By the time parents realize they can't seem to beat it, obsessive–compulsive disorder has made them feel powerless and incompetent, angry at their child, guilty, and

ashamed. Fortunately, there are very effective treatments today for children with obsessive–compulsive disorder.

What Does the Future Hold for Children with Obsessive–Compulsive Disorder?

Obsessive–compulsive disorder is a progressive condition. Understandably, when parents realize that their children's anxiety over their obsession subsides when a certain ritual is performed, they usually end up going along with the ritual. We have learned, however, that giving in to the compulsion only feeds the obsessions. The more the rituals are performed, the more the child's brain seems to demand that those compulsions be obeyed. As a result, more and more time may be taken up by the child's compulsions.

Obsessive–compulsive disorder also tends to be a chronic condition with periodic worsening and improvement of symptoms. Although treatment cannot always provide a complete cure, it will control obsessions and compulsions and prevent them from interfering with the child's life at home, in school, and with friends.

Several research studies have looked at how obsessive–compulsive disorder changes over time. These show that the majority of children with the disorder will continue to show signs of the disorder or will require treatment in adolescence and adulthood. One study showed that half will continue to have symptoms as adults, though impairment from the disorder may be reduced significantly.

One possible complication of obsessive–compulsive disorder is the emergence of tics or Tourette's disorder. These conditions sometimes co-occur. Sometimes the obsessive–compulsive symptoms occur first, sometimes the tics appear first, and sometimes they emerge at the same time. Their overlap seems to be due to some shared biological risk factors. For example, it is possible that some of the genes that influence obsessive–compulsive disorder also influence tics or Tourette's disorder. It is also possible that children with obsessive–compulsive disorder have some of the other biological risk factors discussed in Chapter 3, but more work is needed to know for sure.

A Roadmap to Treatment: Obsessive–Compulsive Disorder*

Medicines

1. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline)
2. Clomipramine

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy
3. Systematic desensitization
4. Exposure with response prevention

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

TOURETTE'S DISORDER

What Is Tourette's Disorder?

Most of us take for granted the fact that we control the muscles of our body. This control is so natural we rarely think about what is required to stand, pick up a glass, pet the dog, or perform any other series of movements. We simply do them as if our muscles were connected to an automatic pilot system in our brain.

But imagine if your muscles moved without your control, if they did things you did not want them to do. That's exactly what happens when a child experiences a tic. Suddenly and uncontrollably, one or more muscles move in rapid succession. Many of us have experienced this on a small and temporary scale, such as when we feel a twitching in our eyelid or other muscle. For most of us, the twitching passes very quickly and does not return; in the case of tic disorders such as Tourette's, these twitches repeat themselves many times and, after they disappear, they usually return sometime soon.

Tics can occur in any part of the body. They are frequently seen in the face, shoulders, hands, and legs. For example, Jason had a shoulder tic. Every now and then, with no warning, his right shoulder would move up and down uncontrollably. His shoulder tic embarrassed him in school, made it impossible to write, led to taunts from other children, and annoyed his parents, who were convinced that he was doing it on purpose.

Jason had a simple tic. Simple tics involve a small number of muscles. Common examples are eye blinking, head jerking, sniffing, neck stretching, foot stamping, body twisting and bending, and shoulder shrugging. The simple tic occurs suddenly and is repeated several times. So if your child shrugs his shoulders once, that is not a tic. If he does it several times rapidly in succession, that may very well be a tic.

Some tics involve coordinated activities and successive movements that use several muscle groups. We call these complex tics. Examples include jumping, smelling objects, touching a body part, and touching other people.

Sometimes tics involve the muscles that control speech. These lead to vocal tics—uncontrollable sounds or speech. Vocal tics can be extremely disruptive and embarrassing. Consider the third-grade girl who every now and then would blurt out swear words in class or at home. Or the fourth-grade boy who would suddenly bark uncontrollably. Other examples of vocal tics are coughing, grunting, yelping, shouting, and repeating the words of other people. Children with vocal tics are usually punished by parents and teachers and teased by other kids. But that cannot help the child control his tics. It only makes him feel worse.

FAST FACTS about Tourette's Disorder

1. A disorder of tics, which are sudden, recurring, rapid, nonrhythmic movements or vocalizations
2. A rare disorder found in about 1 in 5,000 children
3. More common among boys than girls
4. Can start in childhood or adolescence
5. Co-occurs with ADHD, conduct, oppositional, and obsessive–compulsive disorders

You may be wondering why a type of disorder that seems purely physical is addressed in this book on psychological problems. Tic disorders are considered psychological problems for several reasons. For one, they are often treated by psychiatrists. In addition, they can be treated with medications used to treat psychiatric disorders, which means that treatment is usually provided by a psychiatrist since that specialist is most familiar with these drugs. Finally, tics and Tourette's often co-occur with psychiatric disorders. We don't know exactly what causes these disorders; researchers are investigating possibilities like stress right now.

Before you worry too much that your child may have a problem with tics, please understand that many children, especially boys, will show some tics at some time in their life. Most tics are mild and may not even be noticed by other people. So if you see a few tics in our child, there is no need to run to the doctor. But some tics plague children and interfere with many areas of their lives. As we have seen for other psychological problems, you need to learn to recognize the difference between a minor symptom that will go away and a pattern of symptoms that should be a cause for concern. The time to get concerned is when the tics occur many times each day nearly every day or intermittently for a period of more than a year and when they cause your child discomfort or are harmful to his everyday activities.

Most children with a tic disorder will have what we call transient tic disorder. This affects 1 in 10 children before adolescence. We call these tics transient because although they occur frequently for 4 weeks or more, they eventually abate and do not continue for more than 1 year. For unknown reasons, they simply go away by themselves.

But some tics do not go away. When tics last 1 year or more, we call them chronic tics. Chronic tics are less common than transient tics, affecting less than 1% of children. A child with a chronic tic disorder may have only one muscle tic or one vocal tic, but not both. When children show both types of tics, they are given the diagnosis of Tourette's disorder (named after Dr. Georges Gilles de la Tourette, the French neurologist who first described Tourette's disorder in an 86-year-old French woman in 1885).

As you can see from Table 9.2, Tourette's disorder is much more severe than other tic disorders. The child with this disorder will have many motor and one or more vocal tics. These will have lasted for

more than 1 year and the child will not have had a tic-free period longer than 3 months in a row.

If you have a child with chronic tics or Tourette's disorder, you may have suspected that your child can actually control the tics, that he or she is simply using them to get attention, to avoid schoolwork, or to amuse her friends. This is simply not true. The view that the child can control tics is partly an illusion. We are so used to viewing behavior as under personal control that when a tic occurs we try desperately to find an explanation for its occurrence.

This illusion is furthered by the fact that some children with serious tics can sometimes hold back tics for a short time, several minutes to hours at a stretch. But suppressing a tic is like holding back a sneeze. Eventually, the tic will emerge. It is as if holding back the tic creates an internal psychological pressure that must be released. Another reason parents can be fooled into thinking their children can control tics is that the tics worsen in stressful situations and improve when the child is relaxed or busy with a favorite activity. Although we do not completely understand the details, this appears to be due to the biological effects of stress and relaxation.

Keep in mind that even if a tic seems voluntary, your child is unlikely to get anything positive out of it. The guttural sounds involved in some vocal tics simply come across as bizarre and are unlikely to be sought after. Also, a child who was intentionally behaving in ways that appear to be tics would be unlikely to keep it up long enough to

TABLE 9.2. Behaviors Leading to the DSM-IV Diagnosis of Tourette's Disorder

1. Many motor and one or more vocal tics have occurred at some time, although not necessarily at the same time
2. The tics occur many times each day nearly every day or intermittently for a period of more than a year. During this time, the person has not been tic-free for more than 3 months in a row.
3. The tics cause marked distress, are time-consuming, or significantly interfere with normal life.
4. The tics start before age 18.

Note. The symptoms cannot be accounted for by drugs or a medical condition. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

meet the diagnostic criteria just to get attention. The main criteria for these disorders are impairment and frequency; a doctor will have to determine whether your child meets them.

There are also milder forms of these disorders than Tourette's, such as chronic motor or vocal tic disorder and transient tic disorder. These will still cause distress and problems with functioning, though they are less severe than Tourette's.

What Does the Future Hold for Children with Tourette's Disorder?

If your child has some tics, don't be overly alarmed. Remember that many children—as many as 1 in 4 boys and 1 in 10 girls—will have some tics at some time in their lives. So the occurrence of a few tics is perfectly normal and no reason to worry. Parents should worry about tics when they don't go away and begin to interfere with their child's life.

If your child has a tic disorder, his or her first tic will be fairly simple and infrequent. As the disorder progresses, you will see the tic more often. Eventually, other tics may emerge and, depending on the severity of the disorder, you will see both muscle tics and vocal tics. If tics occur for more than a month, or interfere with school, family life, or friendships, you should consult a mental health professional.

Most tic disorders will not progress to Tourette's disorder, which is very rare. Only about 1 in 5,000 children will have such a serious problem with tics. Tourette's disorder is seen in less than 1 in 10,000 adults, which suggests that many childhood cases have a good outcome.

Many tic disorders (about two thirds) will cease in adolescence. Others will persist for many years or even decades, leading to moderate or severe lifelong disability. Even a lifelong tic disorder will show periods of improvement, with symptoms subsiding for several months at a time.

Although lifelong tic disorders are relatively rare, they can be extremely difficult to live with. Some sufferers with tic disorders experience much shame and low self-esteem. They find it difficult to form friendships, so may lead isolated lives. The adult with serious tics often has a hard time finding employment. In fact, one study showed that among adults with serious tic disorders, half were unemployed. Verbal tics can be very difficult to live with. People with

these tics will grunt, groan, or make some other sound for no apparent reason. Less commonly, they will uncontrollably blurt out curse words at work or among friends.

If your child has a serious tic disorder, don't despair. Treatments are available to diminish symptoms and help your child live a normal life. Also, many people with moderate to severe tic disorders have achieved success in diverse fields, including medicine, law, sports, business, and computer science. They succeed through a combination of successful treatment and learning to live with the disorder in a way that limits its impact on their lives.

A Roadmap to Treatment: Tics and Tourette's Disorder*

Medicines

1. Clonidine, guanfacine
2. Tricyclic antidepressants (e.g., desipramine, nortriptyline, imipramine)
3. Clonazepam
4. Antipsychotics

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

EATING DISORDERS

American culture is rife with paradoxes. One of these is how we eat. In this land of plenty, many eat too much and are overweight. Yet at the same time we view thinness as the ideal of physical beauty, especially for women. The message "Thin is beautiful" leaps out from glossy magazines, Hollywood movies, and fashion show runways.

The quest for thinness funds an ever-growing parade of gurus hawking the next great diet to keep America slim.

Some teenagers embrace America's obsession with thinness to absurd and dangerous extremes. They have one of two kinds of eating disorders: bulimia nervosa or anorexia nervosa. This is not to say that eating disorders are caused simply by social and cultural influences. Countries like China have experienced an increase in anorexia with westernization, and we speculate that the rise in eating disorders among males has to do with changes in our standards for male appearance. These are correlations that suggest, yet do not prove, a cause-and-effect link. Currently, scientists view eating disorders as biological conditions aggravated by cultural impositions of ideals of beauty. The mechanisms by which a child or teenager ends up with an eating disorder, and how the disorder is maintained, are very complex and often elusive.

What Is Bulimia Nervosa?

Bulimia, the more common of the two eating disorders, usually starts with binge eating, sometimes in reaction to a failed diet. The teen overeats and then, horrified at having binged, attempts to undo the damage by some type of purging, usually vomiting, excessive use of laxatives, or a very restrictive diet. When the purging phase of the cycle ends, the teen with bulimia binges again, then purges again. It is not unusual for a teen with bulimia to go through as many as 10 to 15 binge–purge cycles in 1 week. Bulimia becomes part and parcel of his or her daily routine.

FAST FACTS about Bulimia Nervosa

1. A disorder of uncontrollable binge eating followed by purging, fasting, or excessive exercise
2. Diagnosed in about 3% of adolescents
3. Much more common among girls than boys
4. Starts in adolescence
5. May lead to anorexia nervosa

Bulimia can be difficult for parents to detect. For many teens with bulimia, bingeing and purging are well-guarded secrets. At family meals the teenager's eating seems normal. But he or she will binge later—perhaps in the bedroom with a box of cookies or when alone in the kitchen, clearing the table, bingeing on piles of leftover food. There will be clues. Cookie crumbs in the bedroom. A missing quart of ice cream. A hidden bottle of laxatives. The sound of vomiting. Its lingering smell. Repeated vomiting may cause broken blood vessels in the teenager's eyes or swollen glands puffing out below the corners of the mouth. The high acidity of vomit erodes tooth enamel, leaving him or her prone to cavities and gum disease. Table 9.3 lists behaviors that lead to a diagnosis of bulimia.

Many teens with bulimia will have shown other signs of psychological problems before the onset of this disorder. They are likely to have had unstable moods. Their parents never can tell if they will be

TABLE 9.3. Behaviors Leading to the DSM-IV Diagnosis of Bulimia Nervosa

1. Recurrent episodes of binge eating characterized by both of the following:
   a. Eating in a short period of time (e.g., 2 hours) an amount of food that is much larger than what most people would eat
   b. A sense of lack of control over eating during the binge
2. Recurrent attempts to avoid weight gain, such as:
   a. Self-induced vomiting
   b. Misuse of laxatives, diuretics, enemas or other medications
   c. Fasting
   d. Excessive exercise
3. Binge eating and attempts to prevent weight gain occur at least twice a week for 3 months.
4. The patient's view of self-worth is excessively influenced by body shape and weight.
5. The disturbance does not occur only during episodes of anorexia nervosa.

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

irritable, sad, happy, or mad. They usually are not pleased with themselves, viewing themselves as stupid, ugly, fat, boring, and so on. Their poor self-image can be pervasive. Frequently they find it difficult to be alone, demanding constant attention from both parents and friends. Sometimes they act impulsively, often with anger or irritability. Their need for other people leads to self-defeating behavior such as temper tantrums and suicide threats. These are usually aimed at manipulating other people to do their bidding, yet frequently lead to what they fear most, the disintegration and loss of important relationships. When relationships begin to work out, they often idealize friends and are easily disappointed.

What Is Anorexia Nervosa?

Bulimia can worsen, leading to anorexia nervosa. There is a connection between these two disorders, though one child does not always end up with both problems. Teens with anorexia seek to reduce body weight by some combination of severe dieting, purging, and exercise. They put themselves on starvation diets, force themselves to vomit after eating, and exercise for hours and hours each day. When they first lose weight, their parents and friends congratulate them. But the teen with anorexia is not satisfied, seeing fat where others see skin and bone. The dieting, vomiting, and exercise continue. The teen falls below normal body weight. He or she looks in the mirror with disgust—not because of wasting away but because some parts of his or her body seem too fat to the teenager. If unchecked, anorexia leads to emaciation, malnourishment, medical complications, and death.

FAST FACTS about Anorexia Nervosa

1. A disorder of failing to attain or maintain normal weight
2. Diagnosed in about 1% of adolescents
3. Much more common among girls than boys
4. Starts in adolescence
5. Often seen in perfectionistic or overachieving teens

Because anorexia is very difficult to treat, parents should be on the lookout for its warning signs. First consider your teen's personality. Many teens start the path to anorexia with a perfectionistic personality. Others will be overly sensitive to criticism. They constantly strive for self-improvement. They feel rejected and unloved at the slightest sign of criticism. Good is never good enough. In their eyes, small failures look like huge defeats. The 98 earned on an English paper is short by two points, and is not an outstanding grade. After a second-place performance at a state track meet, the teen tastes the bitter tears of defeat, ignoring the true magnitude of the achievement.

For most people, perfectionism causes small problems but does not interfere with daily life. But when a teen weighs him- or herself with the scales of perfectionism, anorexia may loom on the horizon. Again, the coincidence isn't inevitable. Perfectionism is a common trait in individuals with anorexia but doesn't cause the disorder. Even though most people with anorexia are overachievers or perfectionists, there are many overachievers or perfectionists who are not anorexic.

A teenager's initial dieting will seem harmless enough. So how do you know the difference between normal dieting and the first steps toward anorexia? There is, unfortunately, no simple test that can answer that question. Instead, you must be alert to clues that raise the suspicion of anorexia.

You will find some clues in your teen's approach to weight loss. Does your daughter idolize a million-dollar, twig-thin model? Does your son lift weights daily in search of sculpted muscles? Do they aspire to achieve an ideal physical image that seems attainable? If your teen has become a vegetarian, what are his or her motives? Love of animals or fear of animal fat? Does the teen strive to exclude both animal and vegetable fat from the diet? If your teen eats more than planned, does he or she vigorously exercise to burn off the extra calories? Is your teen thin yet still trying to lose weight?

Also consider whether the teen has a distorted body image. After completing a successful diet, a normal teen will feel good, making positive comments about his or her new weight and figure. The teen with anorexia will achieve a weight goal, look in the mirror, and criticize him- or herself for still being fat, even though the teen clearly is not. Your daughter may focus on one part of her body, perhaps her thighs, and complain that they are still too fat. If she

TABLE 9.4. Behaviors Leading to the DSM-IV Diagnosis of Anorexia Nervosa

1. Refusal to maintain normal body weight or achieve expected weight gains
2. Intense fear of gaining weight or becoming fat, even though underweight
3. One of the following:
   a. Disturbance in the way body weight or shape is experienced
   b. Excessive influence of body weight or shape on sense of self-worth
   c. Denial of serious medical implications of excessively low weight
4. In menstruating females, the absence of menstruation for at least three menstrual cycles

Note. Using this table may help you determine if your child needs professional help, but it cannot and should not replace the advice of a qualified mental health professional.

describes her body or body parts as being larger than they really are, or has an irrational fear of becoming fat, she may be headed for anorexia. The criteria used by doctors to diagnose anorexia are given in Table 9.4.

If your daughter is a competitive athlete, that puts her at higher risk for an eating disorder. This is especially true for any sport that has her closely monitor her weight (such as ballet or gymnastics) or where lower weight can be an asset to performance (such as track and field events). Some coaches aggressively encourage girls to lose body fat using restrictive diets. Team weigh-ins and public weight postings humiliate athletes who do not meet weight goals. Such methods can lead to anorexia in girl athletes vulnerable to the disorder.

With puberty, girls normally accumulate fatty tissues in their hips and breasts. Because anorexia delays puberty, it helps female athletes maintain a high muscle-to-fat ratio, which makes them better competitors. You should be concerned about any evidence of delayed puberty such as lack of menstruation (or, subsequent to puberty, infrequent menstruation).

What Does the Future Hold for Children and Teenagers with Eating Disorders?

As eating disorders progress, they lead to many psychological and medical complications. The main psychological complications are anxiety, depression, and drug or alcohol abuse. Girls with bulimia may also engage in impulsive, self-destructive behavior.

Persistent bulimia also brings several medical problems. Dental problems are common due to the erosion of teeth and gums by stomach acids. The binge–purge cycle can create fluid loss and low potassium levels. These low levels lead to sometimes deadly heart rhythm irregularities.

The medical complications of anorexia are extreme and severe. The low fluid intake of teens with anorexia leads to chronic dehydration. Cells need fluids to dissolve the minerals that sustain cell life. For example, cells must dissolve calcium to maintain the electrical

A Roadmap to Treatment: Eating Disorders*

Medicines

1. Serotonin reuptake inhibitors (e.g., fluoxetine, sertraline)
2. For bulimia, tricyclic antidepressants (e.g., desipramine, nortriptyline, imipramine)
3. Treatment for co-occurring disorders may help.

Psychological treatment

1. Parent and child education: about the nature of the disorder and its treatment
2. Cognitive-behavioral therapy

*This treatment information is meant only to provide a broad overview of some common treatment options, not to replace the advice of your doctor or mental health professional.

currents that control the brain and heart. Self-starvation leads to low blood pressure, high cholesterol, weak heart muscles, and abnormal heart rhythms. If the teen continues along the path of self-starvation, these heart problems along with assaults on other bodily systems will, inevitably, lead to disease, disability and death. Yes, death. Between 10% and 20% of individuals with anorexia will die from the medical complications of starvation.

Part III

GETTING PROFESSIONAL HELP

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Chapter 10

The Mental Health Evaluation

If you believe your child might suffer from a psychiatric disorder, logic dictates that the next steps should be diagnosis and treatment. But logic does not always convince parents to introduce their child to the mental health care arena. Many parents are nervous about making their first visit to a mental health professional, and they have many questions that you might share: What type of doctor should you see? What types of tests are needed? Should you see more than one doctor? What should you expect from a mental health evaluation? Who will have access to the results? How do you know if a diagnosis is accurate?

This chapter will answer these questions and others that parents ask when they are new to mental health care. The goal of this chapter is to familiarize you with the methods and processes involved in evaluating and diagnosing your child and to help you get the most for your child that this system has to offer.

If you think your child has a psychological problem that warrants investigation by a professional, please don't delay. There are a million reasons to put off seeking professional advice. Maybe you are too busy, as most adults are these days. Maybe you're no longer sure your child needs help now that he or she is doing a little better in school this semester. Maybe you think you were right all along and your daughter is just dieting like her friends. Or your son isn't depressed *all* the time, as your mother points out, so you don't want to be hasty. In my experience, these reasons for postponing a psychiatric evaluation often cover up fears about what might lie ahead. I hope the infor-

mation in this chapter will give you the confidence you need to take a chance on getting a professional opinion and getting any help your child needs.

THE SCREENING OR INITIAL ASSESSMENT

Ideally, the person who diagnoses your child should have several years of experience in diagnosing children with psychiatric disorders. If you suspect your child has a specific disorder, the professional ought to have experience with that disorder, especially for uncommon disorders such as autism and Asperger syndrome. In many cases, however, the best place to start is your pediatrician.

Your Pediatrician: A Good Place to Start

Your pediatrician knows the child's history, including any early signs of the psychological problems that concern you now, and is able to diagnose medical conditions that mimic psychological disorders. As I mentioned in Chapter 3, some people with thyroid disorders experience bouts of major depression, and some rare cases of ADHD are caused by brain diseases. Your pediatrician can make sure your child is not one of the very few children whose psychological problems are caused by a hidden medical condition.

Although most pediatricians do not specialize in mental disorders, they are trained to diagnose and treat these disorders—to a point. The simpler and more common the diagnosis and the more straightforward the treatment, the more likely it is that you will be able to begin and end your search for help with your pediatrician. If your child's pediatrician is not sure of the proper diagnosis, has no experience with the disorder your child seems to have, or cannot provide appropriate treatment, he or she should send you to someone who can meet the challenge posed by your child's condition.

What you can expect from your pediatrician's evaluation of your child depends on several factors. Some pediatricians are experts in children's behavior (they are called behavioral pediatricians), and some may work closely with psychiatrists (such as a pediatrician who specializes in adolescent medicine and knows a lot about teenage psychology). These specialists should be able to han-

dle most disorders, but they are not easy to find. Most pediatricians will be able to diagnose and treat some disorders such as ADHD, yet the majority will only screen for other mental disorders and will send you and your child to a specialist for a firm diagnosis and expert treatment.

Whether your pediatrician chooses to send you to a specialist depends not only on the type of problem your child seems to have, its severity, and the likelihood of your child having more than one disorder but also on practical factors such as the availability of specialists in your area and your insurance coverage. In some health insurance plans, your pediatrician is the gatekeeper to any assessment and treatment that your child receives down the road. For this reason it's important that any examinations the pediatrician does and any decisions rendered, including referrals, be well considered. You will learn how to monitor and deal with the potential problems posed by insurance plans in Chapter 12.

After your doctor rules out physical causes for your child's psychological problems, you—and your child if he or she is old enough—will be asked many questions about these problems. You may also be asked to fill out one or more questionnaires, or the practitioner may fill them out as you answer the questions orally. These might be very general, asking you to describe the types of problems your child has, where the problems cause your child trouble (at home vs. at school, for example), and how long the problems have gone on. Or they could be more specific, zeroing in on a particular disorder that the doctor suspects your child has. Neither of these two types of scales, discussed more fully later in this chapter, is meant to be used to make a final diagnosis, but many professionals, including some pediatricians, will use them to confirm their suspicions when they feel that their experience with the disorder is too slim to rely on their professional judgment alone.

After reading this book you will be familiar with many of the general questions that are intended to provide more information about your child's problems. You'll also know if your pediatrician is not asking questions that are relevant to your child's problems. If that happens, speak up. Don't be shy about telling the doctor anything you believe is relevant to your child's psychological problem. After all, if the doctor does not have all the information, how can he or she make the correct diagnosis?

When the Doctor Decides Your Child Does Not Have a Disorder

If, following the initial assessment, your pediatrician or other clinician concludes that your child does not have a disorder in need of treatment, first think carefully about whether this conclusion makes sense to you. You will not have time to do this during the office visit, but you will at home, where you can consult this book and discuss your concerns with your spouse or a friend.

Fight any urge to go with a "The doctor is always right" reaction if your gut says you know better. If the doctor's conclusion just doesn't fit with what you've been seeing in your child, make a list of the symptoms that concern you most, their frequency, how many different settings they occur in (at home, in school, at church, with friends and so forth), and exactly how you see your child's problems affecting his or her life. Then make another appointment to discuss your list with the doctor. You might find that he or she will be able to calm your concerns and convince you that your child is doing fine or that it makes sense to watch and wait for a few months before making a final conclusion.

But if you remain skeptical of your doctor's conclusion, seek advice from an objective third party who knows your child well. A teacher would be a good choice, because the teacher, like most pediatricians, has experience with many different children and may be able to tell you how "normal" your child's behavior is compared with other children. If the teacher agrees with you, then seek help from one of the experts described later in the chapter. If the expert you consult agrees with the pediatrician, you can rest assured that your child's problems are not serious enough to be considered a mental disorder.

If the doctor says nothing is wrong, you should also ask why your child is having such troublesome problems if he or she doesn't have a disorder. There are several possibilities:

- *The behavior you're worried about is normal for your child's age.* One couple I saw thought their son had ADHD because he seemed hyperactive and overly talkative. After speaking with them and testing their son, I concluded that he was a normal, healthy,

somewhat exuberant child. He did not have ADHD. It turned out that the parents were quiet, sedentary people who were disturbed by even small amounts of noise and activity—they were "underactive" parents with a normally active child. If these parents had taken their child to their pediatrician first, he probably would have come to the same conclusion, possibly without the time and expense of the psychological tests I did. Because they see so many children, most pediatricians have a lot of comparisons for what is normal for a particular age. They may also know the parents well enough to know whether the parents' perspective could be coloring their observations of their child.

- *Your child may be going through a difficult but normal phase.* Besides the "terrible 2s" and the challenging teen years, kids go through periods of baffling behavior, sometimes because of an invisible growth milestone or because of a stressful event in their lives. The diagnostic criteria for most disorders include a minimum length of time that the symptoms have been occurring. If your child's problem hasn't been going on for that long, and the problem isn't severe or overly distressing, a wait-and-see attitude may be the right course.
- *Your child shows many features of a disorder but no signs of distress or disability.* Sometimes a child's behavior is more problematic for the parents than for the child. Maybe you're outgoing and garrulous, whereas your child is shy and quiet. If your child doesn't feel bad about his or her shyness or its effects, and the shyness does not interfere with his or her enjoyment of life or ability to accomplish tasks at home or at school, the child shouldn't be diagnosed with a disorder. If the child's behavior interferes with your life or other family members' lives more than the child's, the child may not have a diagnosable problem. But that doesn't mean you couldn't use or don't deserve help. Your child may not have ADHD, for example, but if he or she is inattentive enough to cause some problems with completing tasks at home or at school, you could probably make use of some behavior management techniques designed for kids with ADHD. *Never hesitate to ask your pediatrician, or any practitioner you consult, for such help—or for a referral to another source for it.*

If you decide to "watch and wait," be sure to keep track of your child's symptoms on a daily basis. Some problems that don't indicate

a diagnosable disorder may worsen, though in fact for many children mild psychological problems go in the other direction and diminish with age. Some shy children, for example, will develop a diagnosable disorder such as social phobia or panic disorder down the road. Some children who are very irritable may become depressed in the future, and others who are very aggressive may develop a conduct disorder. Most kids with mild symptoms are unlikely to have a mental disorder, but keep an eye out for any worsening of symptoms that causes distress or disability. If you decide to keep track of symptoms, don't trust your memory. Buy a small memo pad and, on a daily basis, write down your observations about the nature of your child's symptoms, how frequently they occur, how long they persist, and how they affect his or her daily life. And be careful not to make your child feel self-conscious by interrogating his or her about symptoms or by being too obvious about observing her behavior.

When the Doctor Wants to Treat Your Child for a Disorder

If the practitioner who did the initial assessment has rendered a diagnosis and wants to treat your child, make sure the following important points have been covered:

- *Is the diagnosis accurate?* If the diagnosis is wrong, the treatment won't help or, worse, it could harm your child. Look up the doctor's diagnosis in the appropriate chapter of Part II and review the description of the disorder and the diagnostic criteria in the table. For example, if the pediatrician says your child has obsessive–compulsive disorder, turn to Chapter 9 and look at Table 9.1, which will tell you that children with this disorder have recurring and persistent thoughts and behavior associated with anxiety, along with other symptoms. If your child does not fit this description according to your recorded observations (see Chapter 1), discuss the discrepancy with your doctor. He or she should be able to explain how your child meets criteria for the diagnosis given. If not, you may need to consult an expert.
- *Has the doctor diagnosed all the disorders that your child has?* Your doctor may have given your child a correct diagnosis but missed one or more other diagnoses. This too could lead to the wrong treat-

ment for your child. The best way to find a missed diagnosis is to pull out your list of problem feelings and behaviors again and compare it to the Part II description of the disorder diagnosed by the pediatrician. If that diagnosis cannot account for all of the problems, review all of Part II to see if there is another diagnosis that might account for these symptoms. If you suspect that a second diagnosis should be made, get another opinion.

- *Has this doctor treated many children with the same problem in the past?* If the doctor reports having treated many children with the disorder—successfully—you can probably feel comfortable adding your child to the list.
- *What treatment will the doctor prescribe?* Check the "roadmap to treatment" sections in the appropriate Part II chapter. If the treatment your pediatrician or other initial evaluator is recommending diverges significantly from these standards, ask why. For example, if your doctor prescribes Prozac for your depressed teenager without offering you the opportunity to add cognitive-behavioral therapy to the treatment regimen, he or she may be robbing your child of the fullest treatment gains possible. Ask for a referral to a psychologist who can evaluate whether such treatment is appropriate. Some medical doctors will suggest medicine alone at first, often to spare you the time and expense of seeing another clinician for treatment. Similarly, if your child's initial assessment for ADHD was with a psychologist who suggested behavior therapy but not medication, you should find out whether both treatments are warranted. Some doctors will choose treatments based on their own expertise. But the choice should be yours based on a complete evaluation of your child's needs.

When You Need an Expert's Opinion: Which Professional Is the Right Choice?

Your pediatrician might send you to an expert because of uncertainty about the right diagnosis, because the child's case seems complicated, or because the child will need someone else to provide treatment even if the pediatrician makes the diagnosis. If your pediatrician suggests a specialist, the suggestions you get from him or her will vary widely depending on a number of factors, from the size of your community and the restrictions imposed by your insurance plan

to your child's anticipated needs and, last but not least, your pediatrician's professional relationships with other doctors. If you live in a large city, you will naturally have a large number of professionals to choose from. Your pediatrician may be willing to give you a large list from which to choose or may limit referrals to a choice few that he or she is used to working with. If you live in a small town, you may have to go with the one expert your pediatrician refers you to or be willing to travel far from home. If you live near a large university medical center, you may have access to cutting-edge diagnostics and state-of-the-art treatments. Otherwise, the types of mental health professionals available and their level of training and experience can vary considerably.

Your choice of a specialist can be limited by many outside forces, but you will almost always have some degree of control. If your insurance allows you to choose your doctor, don't throw that choice away. Make an informed decision.

If your doctor is providing referrals, ask these questions:

- *Have all of these people had a lot of experience with the types of problems my child has?* Often your doctor will know which of the professionals he or she is recommending has the most experience, and asking this question invites comparisons that will tease out other useful information too: "Well, Dr. X has more experience with anxiety disorders than anyone else in town, but Dr. Y did her residency at Z University, which is in the forefront of research and clinical practice for these disorders, and then there's Dr. Q, who has less experience but really seems to have a special talent for putting really young kids at ease, which could be very important for your son, who seems to distrust doctors."
- *Which type of expert will be the best choice for us?* Your pediatrician may hand you a list that includes a number of different types of practitioners, in which case you'll need to know what each can do for your child and which type of services your child needs most—or first. Maybe your child needs to have a diagnosis of a learning disorder confirmed and then needs a treatment plan that will help the child compensate for a reading disability. Because testing by a psychologist will probably be needed, a psychologist might be the best first choice. On the other hand, suppose your child appears to have the signs of ADHD, but the total picture seems more complicated.

Even though a psychologist might be able to offer behavioral interventions that your child will benefit from down the road if he proves to have ADHD, the best route right now might be to get an expert diagnosis from a psychiatrist, who can then also prescribe the stimulant medications that are so effective with ADHD. Table 10.1, later in this chapter, will help you compare the different specialists and their respective diagnostic and treatment capabilities, and the descriptions of each specialist will tell you more about who can do what for your child.

- *Who would you call if this were your child?* It never hurts to ask this question, though you may not get a totally candid answer. If you have a long relationship with the pediatrician marked by mutual trust, this question could yield more valuable advice than a dozen other questions.
- *Should we look for a large clinic or a one-person office?* If your child might need psychological testing, medication, psychotherapy, and help with social adaptation, the best choice might be a multidisciplinary practice in which psychiatrists, psychologists, and social workers coordinate their approaches to your child. This could also be best for you if there are practical limitations on your time and ability to transport your child from office to office. But no group will be the best choice if you don't feel confidence and trust in the individual practitioners.

Sorting through the Specialists

In the following pages I'll tell you what credentials the most common types of specialists should have and how you can determine which type of professional to consult initially based on your child's anticipated needs. Of course you will still have to deal with realities such as economics and insurance coverage; Chapter 12 will help you get the most you can for your child despite any restrictions in these areas.

Child Psychiatrists

Like pediatricians, psychiatrists are medical doctors. But where pediatricians are trained during their residency to be generalists who can diagnose and treat a very wide range of physical and mental prob-

Finding an Expert on Your Own

Sometimes you'll be seeking an expert without referrals from your pediatrician, in which case you have a lot more groundwork to do to find the best specialist for your child. You can use the following suggestions to check out a practitioner referred to you as well:

- Ask friends, relatives, teachers, and anyone else you know their opinions about doctors in the area. One opinion may not be worth much, but after asking many people you will find out if there are any doctors you should avoid, as well as any you should try hard to see. Learning about mental health professionals can be more difficult than getting a referral to a pediatrician, because many of your friends may not have had contact with one. Teachers and school officials can be a good source of information because they deal with troubled children on a regular basis. Probably the best source of information would be a local support group for parents of children with similar problems. Attend one of their meetings and you'll have the chance to speak with people who have already had much experience with local mental health care providers.
- When you find people to talk to about local doctors, ask about their overall experiences. Usually, a description of their experience will be sufficient, but be sure these questions end up answered: Have you had any problems with any doctors? If so, with whom? Do these doctors get along well with children? Do they make kids feel comfortable in the office? Will they take the time to answer questions? Has their treatment been effective? Is it easy to get an appointment? How long have they been working with children? What's their specialty?
- When in doubt, call the local university or the mental health center at the best hospital in your area. Other things being equal, a doctor who is on the faculty of a medical school is often a good choice.
- Many newspapers and magazines compile periodic lists of the "best" doctors and therapists in a given area, but they have their limitations. These doctors might just be well known by the media, or they might be so sought after that you'll never get an appointment. Ask your local librarian if he or she knows of any such lists that are based solely on professional competence.
- Ask your own doctors. They may not be as familiar with practitioners who diagnose and treat children, but a doctor you trust will likely give you a trustworthy answer when you ask for a referral.
- Once you start calling practitioners, ask the person who answers the phone about the doctor's credentials, experience with children, and specialty. It's important to confirm what you've heard from

> those who have referred you to this doctor. At the very least, any mental health professional you see should have attended an accredited university, be licensed in his or her specialty, and have had several years experience helping children with problems like those being experienced by your child.

lems in children, child psychiatrists specialize in the treatment of mental disorders in children. They have been trained to handle the complicated or severe cases that are beyond the purview of pediatricians, and they are expert in the medications used to treat mental disorders. Depending on the nature of their training, they will have two areas of treatment expertise: child psychopharmacology (the treatment of childhood mental disorders with medicine) and psychosocial treatment (a broad term that includes many types of "talk therapies") (see Chapter 11).

A child psychiatrist is the best choice if your pediatrician suspects your child's case is complicated or severe. A psychiatrist is also the best choice if your child's problems are likely to require treatment with medication. If you decide to take your child to a psychiatrist, be sure that he or she is board certified as a child psychiatrist. A referring pediatrician should be able to tell you that, and so should the psychiatrist's office. I suggest you use child psychiatrists for their expertise in psychopharmacology, in which case you should look for one whose practice is limited to psychopharmacology or one who offers both. The point is that the doctor's experience with psychosocial treatment should be less of an issue for you. If your child needs medical treatment, you are better off with a psychiatrist who devotes his or her time to learning about the latest developments in medicine. If your child also needs psychosocial treatment, you can find a psychologist who specializes in the type of treatment your child needs.

Child Psychologists

Although both psychologists and psychiatrists specialize in the diagnosis and treatment of mental disorders, psychologists do not go to medical school and are not trained to diagnose and treat physical disorders. They cannot prescribe medication. Instead, they attend grad-

uate school in psychology and, subsequently, a clinical internship. They are taught to diagnose mental disorders and treat them with psychosocial methods. Psychologists are also trained to administer and interpret psychological and educational tests, something that psychiatrists are not qualified to do. I'll describe these tests later in this chapter.

One source of confusion for parents is that there are many types of psychologists involved in the treatment of children: clinical psychologists, counseling psychologists, educational psychologists, neuropsychologists, and school psychologists. To increase the confusion, there are many other types of psychologists who teach in universities or work for businesses but should not be involved in mental health care. The psychologist you choose for your child should have the following credentials:

- Clinical internship training with children
- A state license to diagnose and treat mental disorders
- A doctoral degree, indicated by PhD, EdD, or PsyD after his or her name
- Several years' experience treating the disorder your child suffers from

EdD (Doctor of Education) means that after graduating from a 4-year college or university, the psychologist had an additional 4 years of education focused on psychological issues relevant to education, such as learning disabilities. An EdD may be the best choice if you need a practitioner who has a lot of experience working with schools and who will help your child do better academically. A PhD (Doctor of Philosophy) or PsyD (Doctor of Psychology) has had 4 or more years of training after college and a 1-year internship in the specialty of psychology. Most PsyD and PhD psychologists call themselves either clinical psychologists or counseling psychologists. Clinical psychologists diagnose and treat mental disorders. Although they may also work with children who have problems that do not meet criteria for mental disorders, they usually work with children having more severe conditions. Some counseling psychologists handle the same types of problems as clinical psychologists, but others are trained to deal primarily with children

who have relatively minor problems that would not be considered mental disorders.

When choosing a psychologist, your most important consideration should be how well the skills of the psychologist fit with the needs of your child. If your child's diagnosis is not clear, a clinical psychologist is probably the best bet. If he or she has difficulty learning in school, you would choose an educational psychologist. If your child needs a psychological therapy, you will need to ask questions to see if the psychologist has been trained in methods that can help your child.

Once you have a chance to meet and work with a psychologist, you and your child will develop a feel for this person, a sense of whether or not you can work well together. Although most psychological therapies have well specified procedures, they require the relationship of two or more people: therapist, patient, and parent. If the fit between patient and therapist personalities is poor, you may be better off looking for help elsewhere.

Another subspecialist, the neuropsychologist, is usually a clinical psychologist who has had additional training in specialized methods used to assess mental abilities such as memory, attention, and problem solving. Because not all children need this type of testing, it's best to see another mental health professional first.

Social Workers

Social workers may work in the office of a psychiatrist or psychologist or practice independently, but wherever they work, they play an increasingly important role in the mental health care of children. Social workers usually do not have doctoral-level training and are not trained to diagnose mental disorders. Their role is to explore the relationship between your child's social world and the symptoms that are causing problems. They receive specialized training in evaluating any problems a child has interacting with family, friends, and other significant people in his or her life and also in evaluating features of the home or school environment that may be contributing to the child's symptoms. Most social workers are also knowledgeable about social programs for low-income parents, such as Medicaid and the Children's Health Insurance Program (see Chapter 12).

Choosing among Mental Health Professionals

Table 10.1 summarizes the different types of services provided by the mental health care providers you've just learned about: diagnosis, additional evaluations, and treatment. Although treatment will be the subject of Chapter 11, I've included it here because it will help you understand my recommendations about seeking a mental health evaluation for your child.

As we've discussed, the pediatrician is often a good place to start, but as the table shows, pediatricians are usually not the best choice for the diagnosis of complex mental disorders. In that case, your next step would be a psychiatrist or psychologist. Both are trained to diagnose simple and complex mental disorders, but only the psychiatrist can diagnose physical disorders. If you choose a psychologist, you will need to rely on your pediatrician for diagnoses of physical disorders. If your child has a chronic physical problem like diabetes or asthma, you might want to consult a psychiatrist after your pediatrician, rather than a psychologist, because psychiatrists will know more

TABLE 10.1. The Different Types of Mental Health Care Providers

Areas of specialty	Pediatrician	Psychiatrist	Psychologist	Social worker
Diagnosis				
Physical disorders	Yes	Yes	No	No
Mental disorders	Yes	Yes	Yes	No
Complex mental disorders	No	Yes	Yes	No
Additional evaluations				
Psychological testing	No	No	Yes	No
Educational testing	No	No	Yes	No
Neuropsychological testing	No	No	Yes	No
Social evaluation	No	No	No	Yes
Treatment				
Psychopharmacology	Yes	Yes	No	No
Psychosocial Treatment	No	Yes	Yes	Yes

about the relationship (if any) between the physical and mental disorders and what implications that might have for treatment.

Other than that, whether you choose a psychiatrist or psychologist depends on the type of treatment your child needs. Zach, for example, was diagnosed with ADHD by his pediatrician, who prescribed a stimulant but also recommended additional evaluations because he had a complex and severe set of symptoms, including anxiety and depression. Zach could see a psychiatrist, who would be able to evaluate his medication and monitor the treatment over time. But Zach was also having problems with schoolwork, which was one of the reasons the pediatrician recommended extra evaluations. The best choice here would be a psychologist who specializes in learning problems. A psychologist could confirm (or rule out) the pediatrician's diagnosis and also perform psychological and educational testing. If neuropsychological testing seemed to be needed, the psychologist would be in a good position to refer Zach to a neuropsychologist. A psychologist could also figure out what type of psychosocial therapy would be best for Zach; for example, parent management training, systematic desensitization, social skills training, or cognitive-behavioral therapy (see Chapter 11).

Obviously, Zach may benefit from the help that could be provided by a psychiatrist (for a specialized diagnosis and medication), a psychologist (for testing), and perhaps even a social worker (to help him get along better with kids at school, where he had become disruptive once his academic problems worsened). For him and his family, the best possible avenue of care might be a clinic that offers the services of several mental health professionals. In these multidisciplinary settings, the different professions work as a team and meet together to discuss their views of each child's problem. Professionals working from separate practices might send notes or reports to each other, but they will rarely have the in-depth interactions that occur among a mental health team working together in the same setting.

Another advantage of the mental health care team is that the practitioners are less likely to let personal or professional biases creep into the evaluation and treatment of your child. The old saying "If all you have is a hammer, everything looks like a nail" applies to mental health professions as it does to any other field. A psychiatrist who specializes in drug treatment will likely prescribe drug treat-

ment. A psychologist who specializes in behavior therapy will likely prescribe behavior therapy. A social worker who specializes in play therapy will likely prescribe play therapy. Some of these professionals believe their treatment is best. But no one treatment is always best when it comes to treating mental disorders. In Chapter 11 I will explain how you can figure out what treatment approach makes sense for your child. For the evaluation stage, it's just important to remember that working with a team of mental health professionals can provide you with a wider range of options than you would have by seeing a sole practitioner.

THE ANATOMY OF A MENTAL HEALTH EVALUATION

Whether you've gone through an initial assessment with a pediatrician or you've immediately been referred to another expert, a comprehensive mental health evaluation is the best route to an accurate diagnosis and successful treatment. The evaluation will be composed of at least a physical exam and a mental health interview. In addition, various psychological assessments might be done. Sometimes these follow a diagnosis and are intended not to reveal which disorder(s) your child has but to help the professionals devise the best possible treatment by identifying the child's strengths and weaknesses. Other times they make an important contribution to the diagnosis itself. For example, psychological testing will be done to confirm a diagnosis of a learning disability, but it may also reveal exactly where the disability lies and therefore how it should be treated. Psychological tests are also likely to be done to help with a diagnosis when the child's problems are complicated and/or severe. Some are simply lists of questions for parents to answer. These can be answered at home or in the waiting room. Because they do not require doctors to be present, many questions can be asked, which provide the doctors with more information than they could collect by interviewing. Other tests require the child to perform a variety of tasks such as solving puzzles, recalling stories, reading passages, drawing, or constructing models from blocks. These measure brain functions that might be impaired by mental disorders. But if the child's problems are simple and straightforward, and physical problems have been ruled out, these

additional evaluations may not be necessary. The mental health evaluation might begin and end with the mental health interview.

THE MENTAL HEALTH INTERVIEW

A mental health interview can be done by any professional who is qualified to make a diagnosis: a pediatrician, psychiatrist, or psychologist. It can be very detailed or relatively compact. It might take an hour or be completed over several appointments. The following description is intended to give you a glimpse into what the whole experience might feel like for you and your child, but be aware that some parts described here might be abbreviated in your child's case or even skipped. If you feel that any step has been omitted unwisely, be sure to ask your doctor to explain why.

Typically, the doctor will want to speak with one or both parents and, depending on age, the child. Parents and children may be interviewed together, separately, or both, depending on the nature of the problem. If your child is too nervous or too young to provide useful information, a joint interview will be used. Most doctors will speak with older children, especially teenagers. Before the mental health interview is scheduled, ask your doctor what his or her usual approach is so that you can prepare yourself and your child. (Teenagers can be especially resistant to undergoing a mental health interview and may even refuse to cooperate. See the sidebar on pages 266–267 for suggestions on how to handle this problem.)

Obviously, you're not in a position to describe your child's internal thoughts and feelings, so the doctor has to find a way to get that information from the child. The problem is that not all kids—depending on age and language abilities, along with how outgoing and self-confident they are—can easily put their feelings and thoughts into words. They may be at a total loss to describe how they feel, or words like "nervous" and "sad" may hold a different meaning for the child than for adults. For this reason, the practitioner will talk with the child and may use observations of the child as a way to gather input directly from the child. The interviewer will be watching your child during a joint interview and may also want to watch the child alone at play. Psychological tests also help doctors understand the in-

ner lives of children. Another type of information that children can't supply is their early history. Most kids cannot recall much about the early years of their lives, and that's where you will have to fill in.

Exploring Your Child's Symptoms

The interviewer will ask questions about your child's behavior, thinking, and emotion that will reveal information about the symptoms your child is experiencing. He or she will also review the symptoms of all the mental disorders discussed in Part II of this book. Being asked questions about problems you have not mentioned to your pediatrician may seem like a waste of time, but an important product of any mental health evaluation is a differential diagnosis. That is, it's just as important to rule out what is *not* wrong as to confirm what *is* wrong. Also, most parents are not psychologists and have not been trained to observe behavior in a way that will reveal every possible symptom. The doctor's questions about symptoms that may seem irrelevant are designed to uncover anything that you haven't noticed and that your child doesn't report. So try to be patient during this procedure, which may take up to 2 hours or more.

To speed things up, interviewers first focus on the "presenting problem," the reason you decided to have your child evaluated. For example, if you are seeking help because your child is disruptive and inattentive in school, the interviewer will probably ask detailed questions about these symptoms first. When? Where? How often? What are their effects? He or she should also ask about the symptoms of other disorders known to be common among disruptive and inattentive children, such as impulsivity, oppositionality, learning problems, and rule breaking. Beyond that, he or she may ask more generally about symptoms of other disorders, without asking for each specific symptom. For example, instead of asking about each symptom of every anxiety disorder, he or she may ask a few general questions like "Does your child frequently feel ill at ease or nervous?" and "Does she seem unusually fearful of anything?"

In addition to questions about specific symptoms or disorders, the interviewer will ask many general questions about your child's thoughts, feelings, friendships, school life, and family life. These questions will focus on the what, where, and when of psychological

problems. What are the symptoms? Where do they happen? When do they happen? Your answers will help the interviewer understand three key facts about your child: his or her level of distress, his or her level of disability, and features of his or her life that may worsen the problem.

The interviewer needs to learn about distress and disability because at least one of these must be evident for him or her to diagnose a mental disorder. For example, your child may have many anxiety symptoms, but if these do not cause problems at home, in school, or among friends, the doctor will not make a diagnosis of an anxiety disorder. I use the word *distress* to mean a personal sense of emotional pain. Two examples are the sadness of depression and the panic of panic disorder. Children who are very sad or nervous are hurting inside. They need help.

In the case of depression and panic, the child's distress is a symptom of the disorder. Children can also be distressed by the effects that a disorder has on their lives. Schoolwork frustrates learning disabled children. Difficulties keeping friends sadden ADHD children. Child disorders can lead to conflict among family members, which can make children feel guilty (if they feel responsible for the conflict), worthless (if they feel their parents do not care for them), or fearful (if they think their parents may get divorced because they keep arguing about their child).

When the doctor asks questions about disability, he or she is trying to figure out if your child's problem interferes with the activities of everyday life. An obvious example is autism. Autistic children do not learn to communicate or to socialize as other children do. These everyday activities are seriously impaired. Your doctor will look for evidence of impairment in several areas. See Table 10.2 for some examples.

Exploring the Causes of Your Child's Problem

In addition to the what, when, and where of your child's symptoms, the interviewer will want to figure out the why and how. Why did these problems emerge? How are they maintained?

If a thorough physical examination by your pediatrician or a psychiatrist reveals that your child's psychological problems are caused

TABLE 10.2. Examples of Areas of Disability Discussed in a Mental Health Interview

Relationships
- With friends
- With brothers and sisters
- With parents
- With other adults

Development
- Social
- Emotional
- Intellectual
- Language
- Communication
- Motor

Avoiding harm to self
- Avoidance of risky activities
- Awareness of harmful events

Conscience
- Ability to tell right from wrong
- Level of moral development

Ability to do everyday tasks
- Self-care (washing, dressing)
- Care of possessions
- Ability to organize (e.g., keeping room uncluttered, doing homework
- Ability to do chores or homework without constant parental guidance

School
- Achievement
- Ability to follow rules
- Ability to work in groups
- Reactions to authority figures

Criminal activity
- Drug abuse, stealing, etc. . . .

by a known physical problem, that cause must be treated as soon as possible. It's also possible that your child has a physical problem that worsens a psychological problem. Twelve-year-old Gina has severe asthma and suffers severe and disabling asthma attacks. Though she has had asthma for years and knows it is probably a permanent part of her life, now that she's in junior high she's become very self-conscious (as most girls this age are) about having to be rushed out of the classroom after an asthma attack. She's embarrassed by having to sit on the sidelines when her friends are playing a pickup game of soccer and feels humiliated when her mother "hovers" over her whenever they're out in public. These limitations have been wearing on Gina, and her teacher has started to notice that she is rarely her usual outgoing self these days. She recommended a mental health evaluation when Gina's grades began to drop and she started eating lunch alone.

In a child who is biologically predisposed to depression, the

stress of having a long-standing physical disease can lead to loss of self-esteem, demoralization, and sadness and, eventually, a serious depression. To fill in the picture of what was at work in Gina's case, I had to explore a far-ranging collection of questions aimed at helping me understand the relative importance of all biological and social risk factors. I ended up concluding that Gina had major depressive disorder. Gina had all the symptoms of depression, and these symptoms impaired her schoolwork and her ability to relate to parents and friends. She was indeed "demoralized" about the restrictions her asthma placed on her life, but she could not bounce back from brief episodes of feeling low. She was either sad or irritable for weeks at a time, regardless of her fluctuating medical condition. I also found out that Gina's mother had a history of depression. Because of her family history and her ongoing asthma, I referred her to a psychiatrist to develop a plan for medication and I began a course of cognitive-behavioral therapy aimed at helping Gina cope with her asthma.

Because many types of mental illness are transmitted through genes, any doctor evaluating your child for any psychological problem should ask about cases of mental illness that you're aware of in your child's biological relatives. Taking a family history may help the doctor figure out your child's diagnosis when his symptoms are unusual or complex. For example, suppose your child has many ADHD symptoms but also shows some of the more severe signs that describe children with bipolar disorder, though not enough for your doctor to be sure. Now, suppose one of the child's relatives was hospitalized for bipolar disorder. That would give the doctor more confidence about making a bipolar disorder diagnosis, if other evidence collected during the interview supported this idea.

Diagnoses in relatives will also help the doctor understand the social stresses in your child's life. Suppose that you have been battling depression on and off for most of your adult life. No matter how hard you try to protect your children from any fallout of your own psychological problems, dealing with any kind of illness in the family puts stress on everyone. Even if the child being evaluated does not show signs of depression, it's important for the interviewer to know that the stress of having a depressed parent could be contributing to the child's problems.

It's paramount that you candidly reveal any psychological problems of your own during your child's mental health interview, be-

cause research shows that the longer children are exposed to parental disorders, the worse off they are in terms of their own ability to do well in school, make friends, and overcome psychological problems. In asking about problems you or your child's other parent has, the interviewer is not trying to lay blame or make you feel guilty, but the more the interviewer knows about why your child has problems, the more solutions may emerge.

The doctor may also want to know if there were any problems before, during, or after your child's birth. Were there problems during pregnancy? Did Mom use alcohol or drugs during the pregnancy? Was the delivery normal? Was the child born prematurely? Were his or her weight and health normal at birth? Did the child develop normally during the first years of life? These and other questions about biological risk factors will help the doctor understand the degree to which changes in the brain may influence your child's problems.

Questions about your child's social world will provide information not only about what types of symptoms your child has and how they make his or her life difficult but also about the social stresses that might influence your child's problems. As defined in Chapter 3, stress is any major change to your child's social world. Some of these changes, such as the death of a parent or sibling or fighting between parents, are obvious sources of stress. Others are less obvious. For example, perhaps the child's older brother recently left for college. That change may have had an impact on your child that was difficult for you to notice.

Because change often leads to stress, the doctor may ask you, "Were there any changes in your child's life around the time he started having problems?" Perhaps he was bullied at school, a friend moved away, his mother began a more intense work schedule, his teacher was changed, or a parent remarried. Maybe he got into trouble with the law, lost a pet, had a relative get very sick, or underwent a big change, such as a new school or a whole new group of friends. Even happy events, like a new baby in the family, can be stressful. A parent starting a new job might be very good for the family. The family may be thrilled that a brother is getting married or going to college. The point you need to understand is that change, even change to a better situation, is how we define stress. The reason is that

change requires adaptation. By that I mean that your child must get used to a new situation. That takes time and effort, and that leads to stress.

Preparing for the Interview

Knowing what the practitioner is likely to ask is only the first step in preparing for a mental health interview. The next step is to prepare yourself psychologically. A third step is to prepare your child.

Preparing Yourself Psychologically

If you have never undergone a mental health interview before, you'd be wise to anticipate a couple of potentially unpleasant reactions to the questioning process. Some people begin to worry during the interview that their child's problems are worse than they had suspected, simply because of the sheer breadth and depth of the questions asked. Remember, it's the practitioner's job to make a differential diagnosis—to identify as many real problems as your child has while ruling out those the child doesn't have. Maybe you came seeking help for ADHD and now you're finding out that your child is nervous at school, and on top of that the doctor seems to be asking a lot of questions about drug use. The fact that the interviewer is asking questions about problems you've never noticed in your child does not mean he or she suspects your child has those problems. Although it's natural to be worried about the nature of the questions, do your best to relax and answer as best you can. Usually, a thorough interview does not uncover more problems than the parent already knows about. But sometimes it does, and that is why it's important that you help your doctor learn as much about your child as possible.

You also need to prepare yourself to be as honest as possible during the interview. Most of us are not comfortable sharing family secrets with a stranger, and most of us dread being evaluated by others. We don't like to tell doctors that we're nervous all the time, squabble with our spouse, or have had a history of "the blues." It can be very difficult or embarrassing to tell doctors about alcohol or drug abuse, family violence, inability to read, dropping out of school, or having been in jail. But you must not withhold information for fear of being

embarrassed. It may help to know that your doctor has "heard it all" anyway. What may seem to you like a horrible embarrassment will be a common human trait in your doctor's eyes.

As the interviewer asks questions aimed at discovering aspects of your child's life that might have caused the disorder or might worsen it, you might find some topics seem irrelevant to you; others may seem intrusive. For example, if your child is having problems in school, and the teacher suspects a learning disability, you may be surprised and offended if the interviewer asks questions about how well you get along with your spouse. But such questions are not irrelevant and should not be viewed as offensive. Remember that the interviewer knows next to nothing about you and your family. He or she needs to ask many questions to get a complete overview of your child's life. Some kids do poorly in school because there is so much conflict between their parents that they cannot do homework and cannot shrug off the chaos of their home environment when they're in school. Questions that seem intrusive and irrelevant are, in some cases, critical for understanding your child's problem and how to deal with it.

Many doctors wisely warn parents (and children, too, if it seems appropriate for their age and circumstances) before beginning the interview that some questions may make them uncomfortable or seem irrelevant. At this point they will take the opportunity to tell you that the questions are necessary even if they appear not to be; they should also explain why, as I've just done. They should also assure you that everything you reveal in the interview will remain confidential unless you authorize its release to another doctor or to your child's school.

Gathering Information for the Interview

One of the first questions a mental health interviewer asks is usually something like "Why did you decide to come for an evaluation?" This is your chance to describe your child's main problem in your own words. Be as detailed as possible. Every bit of information you give the doctor is a clue that he or she will use to figure out how best to help your child.

To make sure you include all the salient information, make some notes the day before the evaluation. These notes should list each of

the problems you want the doctor to know about. To organize your thoughts, use three columns on a sheet of paper: problems at home with the family, problems at school, and problems with friends. Then make a separate list of the symptoms that your child shows in each of these settings. Write down only those symptoms that either impair your child or cause him or her distress. Write down symptoms you've seen or heard about recently as well as those you've seen frequently in the past. Table 10.3 is an example of a partial list for 7-year-old Joel.

When you make this list, look over the observations you've recorded about your child according to the guidelines given in Chapters 1 and 2. They may be in an appropriate form to take with you to the evaluation. If not, you can compile your three-column list from them. After you explain to the doctor why you decided your child needed an evaluation, he or she is likely to ask you many questions to clarify the symptoms and how they affect your child.

You should also give some thought to the potential causes of your child's problems. Before you go for the evaluation appointment, do some thinking about stressful changes your child may have experienced around the time he or she started having problems. Make a second list of these changes and take it to the mental health evaluation interview. Because your child's family history of mental illness will be discussed, it's a good idea to give this some thought before the interview. Make a quick list of any relative (including yourself) who

TABLE 10.3. Example of Parent Notes for 7-Year-Old Joel

Problems at home	Problems in school	Problems with friends
Disobeys parent	Calls out in class	Can't wait turn
Fights with brothers	Can't stay in seat	Has few friends
Forgets chores	Fights on playground	Friends set bad example
Is sloppy	Gets poor grades	Cannot play quietly
Is irritable and angry	Has been left back	Makes a big mess
Cries easily	Gets nervous about tests	Says other kids hate him
Wets bed sometimes	Disorganized desk	

needed help from a mental health professional, was hospitalized for a mental health problem, or had serious problems with alcohol or drug abuse. Look over the list you made about your child's symptoms and ask yourself if any relative has had similar problems. Be sure to ask your spouse to help since he or she may be better able to describe relatives in that branch of the extended family.

In all, you should make three lists—one to describe your child's symptoms in three different settings, another to list relatives who have had psychological problems, and a third to describe potentially stressful changes that have occurred in your child's social world. If that seems like a lot of work, remember what Mark Twain said: the shortest pencil is longer than the longest memory. Learn to keep track of key facets of your child's psychological life and you'll have a tool that will be invaluable in supporting any treatment that your child receives in the future.

Preparing Your Child for the Evaluation

How you prepare your child for the mental health interview depends on his or her age, the nature of the problems, and the child's ability to understand the interview process. For a young child it will be enough to simply say that the two of you are going to see a doctor for a check-up. You should explain that this check-up will be different from others. You're not going because you think your child is sick. You're going because he or she has had some problems that the doctor may be able to help with. You can give some examples of the problems in order to give your child a sense of the reason for the check-up.

For young children this conversation will be brief. If they have questions, answer them, but don't go into very much detail. Emphasize how seeing the doctor will be good for your child: "The doctor will help you get along better with other kids." "The doctor will help you stop feeling mad all the time." "This doctor helps children not be afraid of dogs."

Older children, especially teens, may have more questions. Answer them all, emphasizing how the visit can help them with something they see as a problem. You should also tell them that everything they tell the doctor would remain private unless telling another person (usually another doctor or a teacher) would be helpful. Because

of privacy laws, the doctor will not pass on any private information without your agreement. So you have full control over what information is shared with others.

PSYCHOLOGICAL ASSESSMENTS

If your child's problems are mild or clear-cut, the mental health interview might be the end of the evaluation, and the doctor may feel comfortable planning a course of treatment now. If your child's problems are complex, however, the interview may leave some questions unanswered. In that case the mental health interview is the beginning of a longer process. The next step in that process is often psychological assessment.

It's important to understand that the broad collection of tests that fall under the umbrella "psychological assessments" can go by other names as well. You may hear this facet of a mental health evaluation referred to as psychological testing, neuropsychological testing, personality testing, intelligence testing, or psychoeducational testing. Roughly, these tests are designed to evaluate all different aspects of your child's psychological functioning—emotions, behavior, and, especially, the cognitive and perceptual functions that facilitate learning. More and more these days, such tests may contribute to a doctor's diagnosis of your child. As mentioned earlier in this chapter, this is certainly true in the case of learning disabilities. But such tests may also come into play for other disorders. For example, psychological test results from a child with ADHD might lead the doctor to suspect the child also has an anxiety disorder. Or the psychological testing of a depressed child who is doing poorly in school may discover details about the child's learning style that can guide teachers in teaching her more effectively.

Because psychological assessments may contribute to a diagnosis, I'm discussing them now, before talking about the form in which you may receive a diagnosis of your child. But these assessments are equally likely to be made following the diagnosis, and in that role their purpose is to clarify certain issues that are pertinent to devising the best possible treatment for your child. The doctor may be sure that your child has ADHD, but is uncertain about what is causing his

If Your Teenager Refuses to See the Doctor

Sometimes kids refuse to see the doctor for a mental health interview. For young children this usually comes from fear and uncertainty about what's going on, and your reassurances will often persuade them to agree. But sometimes teens can be very difficult about seeking help for psychological problems. If you are the parent of a young child, this is a good reason to deal with problems early. If your child is older, let's think about how you might ease him or her into the doctor's office.

First you need to figure out who is the best person to talk with your teen about seeing a mental health professional. It may be you, your spouse, an older sibling, another relative, a coach, a teacher, or some other adult your teen trusts. Ideally, this would be one of his or her parents, but that's not always so. Some problems have gotten so out of hand that there is little parent-teen communication and little hope that the parent can convince the teen to do something he or she views as not needed.

After you choose someone, you need to decide what he or she might say to overcome your teen's concerns about the mental health evaluation. First try to figure out what your teen views as being a problem. For example, you might view your teen son's alcohol use as a problem. He might not. But he might be upset about some other problem such as not having a girlfriend or not being able to hold a part-time job. Although you might see those problems as less severe, they might motivate him to seek help.

Your teen might also have unfounded fears about what will happen during or after the evaluation. Most of his or her knowledge about mental health treatment is probably from television shows and movies, which are not known for accurate portrayals of mental health services. Therefore, your child might have unrealistic fears—fear of being called a "nut," fear of being put away in a mental hospital with wild and dangerous people, fear of being put on drugs that make him or her feel like a zombie, or fear of electric shock therapy. By talking to your teen you can uncover such erroneous ideas and help him or her set them aside. Let your teen know that all you are asking is that he or she talk to the doctor for a short time. Your not asking him or her to promise to do what the doctor says, take medication, or to go to therapy sessions. After you and your child speak with the doctor, you can work together to figure out what, if anything, makes sense for the next step.

If you have a teenager, you know that their moods can fluctuate dramatically. Some days they are content and easy to talk to, some days they are angry and mute, other times they are hyper and talk too much. Every teen is different, but for most teens some times are better times

than others when a serous parent-to-teen talk is needed. Be careful to choose the right time to speak with your teen. Don't raise the subject when it is most convenient for you. Figure out when is the best time to speak with him or her. Usually, this will be when he or she has had a chance to settle down from the day by watching TV, playing video games, exercising, reading, listening to music, chatting with friends, or doing any other activity that is not stressful.

Eventually, most teens will agree to a mental health evaluation. When yours does, do not waste time in setting up an appointment. In fact, because you usually cannot get an appointment right away, it's a good idea to schedule the appointment ahead of time. Then, by the time you convince your reluctant teen, the appointment will not be too far off.

If your teen has been reluctant, be sure to warn the doctor before the visit. You can do this by seeing the doctor for an initial visit on your own or by calling the office and speaking with him or her or leaving a message with the secretary. This need not be a long conversation. It will help the doctor prepare if he or she expects to deal with a reluctant and, perhaps, oppositional patient.

or her school problems. ADHD can lead to difficulty learning, but the child may also have a learning disability, which could be addressed by appropriate educational methods. Psychological testing can distinguish between the two. The mental health interview of a teenager may have pointed firmly to a diagnosis of depression, but the doctor may wonder if the teen's personality style makes the depression worse. If so, he or she would use a personality test. Or perhaps your child clearly has a reading disability, but its exact nature isn't clear yet. There are tests that can tell the practitioner what type of educational accommodations will be most likely to help your child.

What Is a Psychological Assessment?

Essentially, a psychological assessment is a test of one or more psychological traits or abilities. Because school has taught us to think of a test as a measure of our worth, it's a good idea to use the term "assessment" rather than "test" when discussing these procedures with your child. The goal of psychological assessments is to understand your child's psychological strengths and weaknesses in a manner that

will be helpful in arriving at a diagnosis, planning treatment, and monitoring the outcome of treatment.

There are many different ways to categorize psychological assessments, from the testing method (e.g., self-report or projective), to the domain explored (e.g., home and family assessments vs. educational assessments), to the skill or capacity tested (intelligence tests, speech and language tests, vision and hearing tests, and visual motor skills tests are just a few). It's beyond the scope of this book to go into them all, so in this section I'll provide an overview of what might be in store for you and your child if the mental health practitioner you're consulting thinks that the interview alone isn't enough to give him or her a full understanding of your child's strengths and weaknesses.

The specific tests the doctor chooses for your child and the reasons for choosing them can be too complicated for the doctor to explain and for parents to understand. But it's critical that you do understand the overall purpose of the tests; how important they are to your child's (1) diagnosis, (2) treatment, and (3) treatment monitoring. You also need to know what they will entail for you, personally and financially, and for your child, especially, emotionally. As you'll read in Chapter 12, many insurance companies still do not recognize the full value of psychological assessments and may not cover the tests that your doctor wants to perform. I strongly urge you to work with your doctor and insurance carrier to find a way to make the testing possible if you agree with the doctor that the tests will be beneficial to your child. The more you can learn about what's wrong with your child now, the more quickly your child can get help that will improve the quality of his or her life and the outlook for the future.

Not all children with psychological problems need psychological testing. As a general rule of thumb, the more complex and severe a child's problems are, the more likely it is that he or she will benefit from testing. For example, a teenager who has a phobia of flying on airplanes would not usually need any testing. Diagnosing and treating the phobia is straightforward. If no other problems are evident, testing will probably not be considered. But if the same teen was chronically irritable, had deteriorated at school, and admitted to alcohol and drug use, testing would be in order to more accurately determine the nature of the problems and targets for treatment.

The difficulty in deciding whether to test or not is captured in

the phrase "If no other problems are evident. . . . " This assumes that the doctor has completed a comprehensive interview of the child and parent, inquiring about a wide range of symptoms and impairments in home, school, and among friends. But due to the rules of many health insurance plans, many doctors, especially pediatricians, do not have much time to ask questions. When I teach doctors about psychological assessment, I tell them to use questionnaire assessment measures if they have time for only a brief interview. These methods usually detect problems that are otherwise "not evident."

I also suggest psychological testing whenever the child is having difficulties in school. Some doctors might tell you your child does poorly in school because he or she misbehaves, does not pay attention, is not trying hard enough, is not motivated, or for some other reason. But this type of conclusion is very difficult to reach in the absence of test data. Of course your doctor might be right. If you find yourself in this situation, you should ask the doctor how the proposed treatment will help the school problems. He or she might say, for example, that medication for ADHD will likely resolve the school problems, which is true for many children with ADHD. You will then need to track progress at school to see if medication helps. If not, psychological testing is probably warranted to see if it can find other targets for treatment, such as having the teacher accommodate to the child's learning style.

If your doctor recommends psychological testing, ask the following questions:

- Exactly what can this test tell us about our child? (Ask this questions for each test recommended.)
- Why hasn't the interview you've done so far produced this information?
- How and where will this test be performed? (You'll want to know who will be doing the testing, whether you'll be with your child, whether the test will be verbal or written, and how long it will take.)
- Have any other children you know who have had this test found it stressful in any way?
- What should we do to prepare our child for this test?
- If our insurance plan will not cover the cost of this test, how

much will we have to pay out of pocket? Are there are any alternatives that might cost less but produce the same quality and quantity of information?
- What would the consequences be of deciding not to go through with this test?
- Will the tests help determine if our child requires special services from the school?

Preparing for a psychological assessment is pretty easy. You need to do two things: Send any relevant information to the psychologist and explain to your child what will happen during the evaluation. By "relevant information" I mean (1) school achievement records, (2) prior psychological test results, and (3) reports from other health care professionals who have already seen your child. There are three types of school records that would be useful: report cards, written reports of school behavior, and standardized tests, which are tests given to all students in a school district and, sometimes, all students in a state.

It's best to send this information to the psychologist before the day you bring your child for testing. If you bring it on testing day, the psychologist will not be able to use the information to plan the testing session. But if you give it to him or her ahead of time, the psychologist will be able to use it to design a better testing session. For example, if a parent gives me the results of a recent intelligence test, I will not repeat that test. School records can be helpful in several ways. They might tell me that a child has difficulty learning in a particular subject or that, for him or her, some teaching methods work better than others. These clues would point me in the right direction in planning the best testing session possible.

To help your child prepare for the testing session, you need to first speak to the psychologist to get a general idea of what is planned. How long with the session last? Who will do the testing? Will any of the tests remind your child of school tests, for example, tests of reading or arithmetic ability? Will your child be able to take a break if he or she is feeling tired or stressed by the testing? Many psychologists will help your child prepare by meeting with him or her before the testing session and answering these questions. Depending on your

child's age and communication abilities the psychologist may do this with or without a parent in the room.

Because most children are at least a bit nervous when meeting a new adult, especially a doctor, it is best if your child has had at least one meeting with the psychologist before the testing session. If your child is nervous, upset, irritable, or otherwise perturbed, it will be difficult for the psychologist to get meaningful test results. A child who is very nervous may do poorly on all tests due to nerves, not mental abilities. That would make it impossible for the psychologist to figure out his or her strengths and weaknesses. For the same reason, be sure your child has had a good night's sleep and a good meal before the testing session.

In the mental health interview, the interviewer relies on his or her training and experience to acquire a good sense of what constitutes normal and abnormal behavior. Behaviors that are clearly signs of a problem—cocaine use, for one simple example—do not require the interviewer to make mental comparisons with other children. Psychological assessments are another way for practitioners to define abnormality. By testing many children with the same test and learning about the range of test results to be expected, mental health professionals can easily describe the results of one child's assessment as either high, average, or low. This makes it easy for them to determine which of your child's abilities are unusually weak or unusually strong compared to other children. For example, when intelligence tests were created they were given to thousands of children. When these thousands of scores were analyzed, the average score was 100. So if your child gets a score of 100 we know that his or her intelligence is average. That means your child is more intelligent than about half the children his or her age and less intelligent than the other half.

Thus, psychologists can quickly figure out how your child compares with other, same-age kids. The goal of the comparison is not to grade your child. Instead, the goal is to figure out his or her psychological strengths and weaknesses so these can be used to plan an effective treatment program. For example, Lewis's parents sought help because Lewis was reading poorly in school. I was asked to help figure out why. First, to figure out his reading level, I gave him a reading test, which showed he read worse than 9 out of 10 children his

age. Despite being in the second grade, his reading ability was even worse than most first-graders. Yes, he had a reading disability.

The next step was figuring out why, a complicated affair, sort of like detective work. Because he had had a mental health interview I knew that he also had ADHD but no other disorders. My job was to figure out if he had problems with some of the abilities needed for reading. If a child has very poor vision, so poor that he sees only blurry blots of ink where others see words, he will not learn to read without eyeglasses. Vision is an obvious example of an ability needed for reading. There are many more such abilities. Imagine a child with perfect vision who sees letters as sharp, distinct forms. To learn to read, his brain must be able to figure out the sequence of the letters in the work, where one word ends and another begins, which part of the letter is up and which is down, which letter or group of letters matches up with what sounds and which words match up with what meanings. And those are only a few examples of the many skills we need to read.

It turned out that Lewis had a very specific problem. For him, matching letters and groups of letters to sounds was nearly impossible. Fortunately, all of the other skills he needed for reading were intact. Other kids with reading disabilities are not so lucky. I shared the test results with Lewis's parents and teacher. Together, we figured out what would be the best method for teaching him to read. We didn't cure his problem. By understanding what skill was weak and which were strong we were able to let him use his strengths to work around his weakness. Lewis will never be an outstanding reader. But today he's as good as the average kid in the eighth grade.

How and Where Psychological Assessments Are Performed

Some psychological assessments will remind your child of school tests. Examples include tests with mathematics, reading, or vocabulary questions. Many other tests have little resemblance to school. They may ask a wide range of questions about habits and preferences or may request your child to perform specific tasks such as arranging blocks in a pattern, arranging pictures to tell a story, or recalling a story from memory.

For some psychological assessments the child simply answers

written questions. We call these questionnaire assessments. Others require a one-on-one interaction between the psychologist and the child. This interaction is not simply conversation, as it requires the child to respond in specific ways to objects or words presented by the psychologist. For example, the psychologist might give the child a set of puzzle pieces and ask him or her to assemble them into a familiar object. Or he might read a list of words and ask the child to repeat them or to recall them 20 minutes later.

Tests that measure overall intelligence and specific mental abilities that contribute to intelligence are taken in a one-on-one session in which an examiner will ask your child questions or have him or her do specific tasks. The use of a one-on-one session is very important. In it, the psychologist creates a comfortable setting with few distractions so that your child will perform as well as possible. It also allows the psychologist to observe how your child reacts to tests and solves problems. These observations will help the psychologist figure out if anything is wrong with the way your child thinks.

If your child is sent for a neuropsychological evaluation, the tests will usually be given by either a neuropsychologist, a clinical psychologist, or a school psychologist. Your best bet is to go to a neuropsychologist because neuropsychologists have received specialized training in the use of neuropsychological tests. Sometimes you will not have a choice because of your health plan or the school's referral network. If you cannot see a neuropsychologist, don't worry—most clinical and school psychologists have extensive training in this area. Whatever you do, keep in mind that psychologists who have a doctoral degree have more training. If you are able to choose among several doctoral psychologists, call their offices and ask the staff if the doctor has had specialized training in neuropsychology.

Some psychologists will instead have a psychometrician test your child. Although not doctors, psychometricians have been specially trained to administer psychological tests. Just as nurses and physician-assistants work with physicians, psychometricians assist psychologists. Although the use of psychometricians produces correct test results, if you have a choice, it is best to have the psychologist test your child, for two reasons. First, there are no formal training programs or guidelines for training psychometricians. That makes it difficult to know if they have been trained properly. Second, although

well-trained psychometricians will administer and score tests correctly, they are not trained to observe test behavior, so they may miss valuable clues about your child's problem that a psychologist would observe.

You might be wondering what it feels like to take a psychological test. Some tests will be similar to other experiences you have had. When you answer questions on a rating scale, it's just like filling out any questionnaire, except the questions are about thoughts, feelings, and behavior. Some doctors will have you fill these out in the waiting room; others will have you take them home. Some questionnaires are long and can take an hour or more to fill out. It is also likely that some of the questions in the questionnaire may have already been asked by the doctor. So these can sometimes be tedious to fill out.

Tests that require your child to interact with a doctor or psychometrician will be given at the doctor's office, either in the same office used for the interview or one that is nearby. You do not need to worry about your child being stressed or upset by these tests. Test examiners are trained to make children feel comfortable in the testing situation. Depending on your child's age, the examiner might speak with him or her beforehand or play some board games. This helps establish rapport so your child is comfortable in the testing situation. Many children enjoy the testing session as it usually involves puzzles, drawing, and problems that are not too similar to what they face in school. But some tests are school-oriented, and these may bore or annoy your child, which is especially true if the session lasts too long. But because examiners are trained to monitor you child's emotions during the session, these negative feelings should be mild if they occur at all. In fact, examiners should stop the test session if stress or fatigue appear to be interfering with the child's performance.

Types of Psychological Assessments

Symptom Rating Scales

You've already been introduced to symptom rating scales in this chapter, and your pediatrician or your child's teacher may already have filled one out on your child. In fact they will probably be the first "tests" that you and your child will encounter during a mental

health evaluation. These are the scales that I described earlier that are often used when a practitioner is uncertain about his or her ability to judge whether a child has a particular disorder based solely on clinical experience with that disorder. A symptom rating scale is a psychological assessment that asks questions that are directly relevant to the symptoms of the disorder in question. Many of these questions will be similar to the kinds of questions asked during the mental health interviews. Unlike the interview, the questions are printed on a form, which also includes a set of possible answers for each question. These scales look a lot like the multiple choice tests you may recall from high school or college.

Because of the printed format, the questions are always asked in the same way and the answer is constrained in some manner. For example, a rating scale might ask: "Does your child get in trouble at school?" For some scales, the answer might be limited to yes or no. For others, you might be able to choose among several choices: all the time, frequently, sometimes, every now and then, rarely, not at all. Because the questions are always asked and answered in the same format, the psychologist can compare the results for your child with those of a large number of other children.

Your child may be asked to fill out a symptom rating scale (if he or she is old enough to give sensible answers). Parents and teachers may be asked as well. Rating scales have one clear advantage over interviews: They can be completed relatively quickly and do not need to be filled out in the doctor's office. This is especially important for getting information from teachers who rarely have the time to talk to doctors about their students. But these convenience features of rating scales mean that they cannot be as thorough as an interview. Because of that, rating scales alone cannot lead directly to a diagnosis.

If your pediatrician has done an initial screening on your child, you may already have seen these rating scales. Schools sometimes use screening tests as well, to identify children at high risk for mental illness. Schools with screening programs will identify "high-risk" children and suggest that their parents seek a comprehensive mental health evaluation.

Doctors also use rating scales for treatment monitoring, discussed in Chapter 11. After your doctor decides on a treatment plan, he or she will need some way to figure out if the plan is working. In

many cases, all the doctor will do is ask you questions about your child when you return for a follow-up visit. But many doctors will also ask you, your child and, perhaps, his or her teacher to fill out rating scales. By tracking your child's improvement (or lack of it) with rating scales, the doctor can decide if the original treatment plan is working. If the rating scales show the treatment to be working, the doctor will stay the course. But if your child's problem is worsening or even not improving, the doctor will adjust the plan until he or she finds one that works.

Intelligence and Achievement Assessments: Neuropsychological Tests

How are our thinking processes organized? That question has been the topic of a centuries-old debate, from which two observations have emerged: (1) Efficient thinking calls on many different abilities such as memory, language, and attention, and (2) just as some people are physically strong and others physically weak, some are very efficient thinkers while others are less efficient. When psychologists created mental tests in the early 20th century, they found that people who did well on one mental test tended to do well on others. This led Dr. Charles Edward Spearman to conclude that all humans had a single trait that determined how well they would do on different types of mental abilities. He called that trait *g,* but it is now referred to as intelligence. Other psychologists argued that *g* was an artifact of Spearman's experiments. They believed that instead of having one unitary trait that determined our mental functions, each mental function, being separately controlled by different parts of the brain, should be considered a separate trait.

After many decades of research, psychologists agreed that both sides of the debate were partially correct. We can measure a trait of intelligence. When we do, we find that people of high intelligence tend to do well on most mental tasks while people of low intelligence tend to do poorly. But we can also measure the different mental tasks separately. When we do, we find that people can be very smart on one task but not so smart on another. This distinction is extremely important to your child, because it is here that we can determine what a child is really capable of achieving in school and in other tasks that

require thinking skills. Which brings me to my principal piece of advice about intelligence tests: Don't obsess about your child's intelligence quotient (IQ) if you come across it in a psychological report. Worrying about a child's low IQ or overfocusing on a child's high IQ will distract you from the task at hand: learning about your child's pattern of mental abilities.

In addition to mental ability tests, your child may take achievement tests, which measure what your child has learned by applying his or her abilities. These tests are similar to the tests your child takes in school because they measure specific types of knowledge such as reading, spelling, and arithmetic. A child's mental abilities are analogous to a person's natural athletic ability. For example, a girl who has lots of speed, coordination, ball sense, and agility may end up being very good at tennis, but before she has had a single lesson or played a single game, her achievement in tennis will be nil. With lots of practice, her achievement may end up matching her abilities. The same is true for mental abilities and achievement. And as with athletics, sometimes achievement does not keep pace with ability. Some children earn grades in school that are lower than expected for their level of mental ability. Psychological tests can help sort out why these children are not living up to their potential.

Tests that measure mental abilities and achievement are called neuropsychological tests. Psychologists use neuropsychological measures for several reasons. The results of these tests will tell you if what your child has learned is what we would expect from his or her abilities. For example, Fred, a fourth-grader, was doing very poorly in school. His pediatrician diagnosed him as having ADHD and requested a psychological evaluation. The psychological tests showed that Fred was a very smart boy, much smarter than his teachers suspected from his school achievement. The psychologist concluded that Fred's ADHD was interfering with his natural ability to learn. Several years later, after treating Fred's ADHD with medication and accommodations in school, his achievement rose to a level that was close to his potential.

Psychological tests will also tell if your child has a learning disability. Unlike Fred, whose achievement suffered in nearly all subjects, children with learning disabilities usually show poor achievement in only one area, such as reading or arithmetic. LaTanya and

Pat, both sixth-graders, were reading at the third-grade level: When I tested them, I found that Pat was not very intelligent. Most of his mental abilities were weak. He could not remember what he was told; he had a hard time separating different sounds; he could not organize his thoughts; he had poor language skills, and so on. I concluded that his reading achievement was as good as one would expect given his abilities. In contrast, LaTanya was a bright girl. Most of her abilities were above average. She should have been reading at grade level or above, but was not. As you can imagine, it was important for me to know the different mental abilities of these children. The tests helped me and the teachers figure out the best way to help these differently-abled children, even though both seemed to have the same problem, low reading achievement.

If your child has a mental disorder or learning problems, you may be used to teachers, psychologists, psychiatrists, and other professionals describing your child's problems. But for all phases of assessment it is crucial that you and your child's caregivers also examine you child's strengths. Indeed, the goal of neuropsychological testing should be to describe your child's pattern of mental ability, a pattern that will include both weak points and strong points. Learning about the weak points will help professionals figure our what is wrong, what needs to be fixed. Learning about strong points will help them figure out how your child may be able to use strengths to compensate for weaknesses.

Be sure your child is told about his or her strong points. I find doing so helps children understand themselves and also gives a boost to their self-esteem. Jawan, a high school freshman, did very poorly in school, argued constantly with his parents, and was being treated for alcohol abuse. Although he did poorly on tests measuring academic skills, he scored better than 99% of his peers on a test measuring mechanical ability. This buoyed his spirits. He stopped seeing himself as a "loser" and began to make career plans that would capitalize on what had been a hidden skill. Make sure your child's doctors don't get so overfocused on your child's problems that they don't recognize mental abilities that at best can help with treatment and at a minimum can be used to help the child feel better about him- or herself.

Mental Skills That Intelligence and Achievement Tests Measure

Table 10.4 provides an overview of the many types of abilities measured by neuropsychological testing. On the following pages I'll describe some of the mental skills tested by psychologists with some examples of how they are tested. As you can see, intelligence has many, varied components.

One of our most basic mental skills is *orientation*, the ability to locate ourselves in place, time, and space. If our brain is working correctly, we should know where we are, and about what time it is. Psychologists test orientation by asking obvious questions such as "Do you know where you are?" "What day it is?" "What time it is?" or "Which way is left?" They might also give instructions such as "Touch your right ear with your left hand."

The term *motor skills* refers to the ability to make coordinated muscle movements. Psychologists include motor skills in tests of mental abilities because, like orientation, the strength and agility with which we move and coordinate movements tells the psychologist a good deal about how well the brain is working. To measure agility the examiner might ask your child to tap his or her finger as many times as possible for 10 seconds. To measure strength, he might ask your child to grip a device that measures hand strength.

Without *perception*, we would never be able to learn about the

TABLE 10.4. Types of Neuropsychological Abilities

Orientation: knowledge of place, time, body and space
Motor skills: dexterity, strength, coordination
Perception: sensation, organization, discrimination
Attention: vigilance, mental tracking
Memory: recognition and recall of meaning and events
Verbal ability: language, reading, writing, spelling, talking
Construction ability: copying, drawing, building, assembling
Concept formation: understanding abstract ideas, reasoning
Executive functions: planning, organizing

world around us. One test of visual perception has the child look at a paper on which many different symbols are printed. The task is to cross out one type of symbol as quickly as possible. Another test presents a partially complete drawing and asks the child to guess what it might be. One test of auditory perception tests the child ability to hear the difference between different combinations of letters such as "br" and "pr."

We all become familiar with the concept of *attention* from an early age when our parents admonish us to "pay attention!" Without the ability to focus or concentrate, we would find it very difficult to make sense of our world. Neuropsychologists have discovered several types of attention. The simplest type is seen in how fast we can press a button after some event occurs, how fast we can react. Vigilance is the type of attention that requires us to focus on a task for a long period of time. To test this, psychologists ask individuals to look at a computer screen for a while and press a button every time they see the letter *A* flash on the screen. Children with poor vigilance will take their eyes off the screen and miss some of the A's. Some children can attend well to one thing but have problems when focusing on more than one is required. Their capacity for attending seems to be limited. This capacity is tested by asking them, for example, to attend to a series of digits and then repeat these back to the psychologist. Obviously, problems with attention are a main feature of ADHD.

How would we survive without *memory*? To a psychologist, what you think of as memory is actually many abilities: episodic memory to recall events from our life, semantic memory for the meaning of words or objects, recognition, and recall. Another way to divide up memory is by the different senses. We have memory for visual images, sounds, tastes, textures, and smells. Psychologists test auditory short-term memory by asking children to repeat a series of words, letters, or numbers immediately after they are spoken by the psychologist. They test visual short-term memory by showing the child pictures or drawings and then asking the child to indicate what has been shown by either speaking an answer, drawing a copy, or pointing to the correct answer. Long-term memory is tested by adding a delay between the time the psychologist gives the things to be remembered and the time the child is asked to recall what they were.

Verbal ability covers many skills needed to use and understand

language. We need to read, spell, write, and speak to communicate with others. Children with low verbal ability do poorly in school and often find it difficult to make friends. Psychologists divide language skill into receptive and expressive abilities. Receptive language ability is the ability to understand language, to make sense out of what others are saying to you. Expressive language ability is the ability to express ideas using language, to make yourself sensible to others. There are many tests of verbal ability. Some simply ask questions or ask the child to name objects. Others test vocabulary skill using either words or pictures, and some ask the child to say or write as many items as possible in a specific category such as animals or toys. Tests of reading, writing, and spelling are also used to determine how well the child has learned these verbal school-related skills.

Schools tend to teach and test verbal ability and achievement, but your child's ability to draw, do jigsaw puzzles or play with blocks—his *construction abilities*—are also important to learning. Psychologists may ask your child to copy a drawing or to draw a picture of some everyday object such as a person or a clock. Another method uses a set of partial and fully colored blocks. The psychologist shows the child designs and has him or her put the blocks together to match the design.

Concept formation, the mental process we use to create concepts like the abstract ideas of truth, beauty, and love as well as classifications (the concept of *fruit* meaning many different types of apples, pears, etc.), is essential to language and to thinking about anything that we cannot sense. Because of this, children who have deficits in concept formation will struggle in school, misunderstand others, and have difficulty reasoning. One concept formation test asks the child questions about how two objects are similar to one another—for example, "How are a dog and cat alike?" The correct answer (both are animals) shows that the child understands the concept of "animal." Another test is like the *Sesame Street* game "Which one of these is not like the others?" It shows the child a series of pictures and asks which does not fit in. For example, among pictures of a cat, dog, horse, elephant, and baseball, the baseball does not fit in. Sometimes the test uses designs having no meaning instead of pictures. There are several sorting tests that ask the child to sort a group of objects into meaningful categories. This could be as simple as separating ani-

mals, toys, fruits, and cars. Other sorting tests are more complex, requiring the child to notice subtle features of designs such as shape, color, and number of objects and how these features make designs different and similar to one another.

As their name suggests, the *executive functions* form the management control center of the brain, taking charge of all the information collected by our senses and then making "decisions" about how to behave. By organizing information, motivating actions, being aware of our surroundings and planning responses, our executive functions help us accomplish the many tasks we face each day. For many years, psychologists have used paper-and-pencil mazes and tests that seem very much like puzzles or brain teasers to assess executive functions. Other tests of creative thinking ask the child to list possible uses for common objects.

How Neuropsychological Tests Contribute to Diagnosis and Treatment

Usually, there are two phases of neuropsychological testing. In the first phase a short assessment measures intelligence and some component abilities. Based on the results of these tests, the psychologist will decide whether the child needs a longer, more complicated assessment. The main reason for using two phases is that a complete assessment of neuropsychological abilities is very time-consuming and expensive.

If the first phase of testing shows no problems, there will be no second phase. For example, when I tested Jamie, I found he had above-average abilities and achievement even though he was doing poorly in school. I concluded that his problems in school were caused not by defects in mental ability but by his disruptive behavior. I decided that, instead of a second phase of testing, he needed an additional interview to figure out the nature of his behavior problem.

For other children, the first phase of testing shows problems that suggest a second phase of testing will be useful. For example, Sandra was referred for testing because her parents were concerned about her school performance, which they thought should be better. Testing showed Sandra was a low achiever. It also showed she had below-average intelligence. This low level of ability was seen for all the abil-

ities measured in the first phase. I decided we needed to know more about Sandra's abilities to help her teacher figure out the best way to teach her. The second phase of testing found two useful facts about Sandra's mental abilities. When she learned something by hearing it spoken, she learned it better than if she saw it written down. Also, she could express her thoughts very well by speaking but had much difficulty writing. After discussing Sandra's pattern of mental abilities with her teacher, we put together a teaching plan that fit with her style of learning and expression.

Family Assessments

Here's another type of assessment that you've already been introduced to. Earlier I talked about the fact that the mental health interview will always include questions about your family and home life. This information is relevant for several reasons. For one, we know from much research that most psychological problems run in families. Another is that parents who have serious psychological problems may not be able to fully participate in helping their child. As you will read in Chapter 11, most treatment approaches require some help from the parent. This help could be as simple as recording the severity of the child's problems to trying out new methods of discipline. A parent who is seriously impaired by a psychological problem will not be an effective participant in treatment. The fact that you're reading this book certainly implies that this is not true of you. But you may have other limitations on your ability to help, such as several other children who already take up all of your time or two jobs or another child with a disability or an alcoholic spouse. For your child's sake, the mental health practitioner needs to know about any such factors in your home life. Families create an environment in which children spend a good deal of their lives. Some families are supportive and loving; others are fraught with the tension of an unhappy marriage or constant bickering among siblings. Some parents are calm, relaxed, and satisfied with their lives. Others are stressed out by the demands of work, the pains of physical disease, or the adversity of poverty. I am describing extremes to make a simple point. The nature of the family can influence a child's psychological problems. Your doctor needs to know about your family environment.

There are many ways to collect this information. Many doctors will simply interview one or both parents or have them fill out a paper-and-pencil questionnaire. Some questions will ask about mental health disorders in other family members. Others will ask you to describe what life is like in your home. The doctor might ask questions like "Do family members criticize one another?" "Is there physical fighting?" "Do you enjoy each other" "What types of family activities do you do together?" These and other questions will give the doctor an idea of how much conflict occurs between family members. They will also tell him or her how well the family functions as a unit to solve problems, overcome adversity, and create a loving, secure home atmosphere.

WHAT CAN YOU EXPECT FROM THE DIAGNOSIS?

After the interview is completed and any testing recommended has been done, you can expect the doctor to make a diagnosis. As mentioned earlier, the doctor's conclusion may be that your child doesn't have a diagnosable disorder. As with the pediatrician, you should then ask what you should do now. But let's assume the doctor has, in fact, found that your child fits the diagnostic criteria for a particular disorder. What will the doctor tell you?

The doctor should tell you the name of the diagnosis (or diagnoses) that fit your child, along with proposed treatments for these diagnoses. He or she should also give you some sense of the severity of the disorder and its implications for your child's future. For example, you might learn that your child has obsessive–compulsive disorder and that the suggested treatment is a combination of medication and cognitive-behavioral therapy. You will also hear comments like "Your child has a mild case, which we've caught in its early stages. I'm confident that the treatment will let him leave a normal life" or, in more severe cases, "Your child has a pretty severe case, and I'm worried that he might be at risk for depression. I'm sure we can be of much help, but he may have to struggle with this disorder for most of his life."

Most doctors will not give you a written report unless you ask for one. If your child's problems are relevant to his or her performance and school, you should ask the doctor to send a written report to your

child's teacher(s). A copy should also be sent to the school's principal. If the doctor has concluded that your child's psychological problems hinder his or her ability to benefit from the standard education provided by pubic schools, the report should clearly indicate the nature of each problem and how it interferes with learning. This is necessary to show that your child qualifies for legally mandated special education services (see Chapter 12 for more details).

Another reason to request a written report would be if you plan to have your child seen by other doctors. For example, some children will see a pediatrician, a psychiatrist, and a psychologist. Each of these doctors should communicate their findings to the others. Because your child's medical record is confidential, it should not be shared with anyone outside the doctor's office without your written consent. You also have the right to release only part of your child's report. For example, if your child's doctor sends a report to the school, you can ask him or her not to include any information about your family's history of mental disorders.

MOVING ON TO TREATMENT . . . BUT FIRST, IDENTIFY YOUR CHILD'S STRENGTHS

As I said earlier, it's important that a mental health evaluation identify your child's strengths as well as weaknesses and that those strengths be communicated to your child. These strengths will be the child's tools for getting the most out of any treatment, just as they are his or her means of achieving success and happiness at school, at home, and with friends. They also protect the child from falling prey to the full brunt of risk factors. If a child with a strong genetic predisposition to depression has to deal with weighty stressors like the death of a loved one, a physical illness, or a crime-ridden community, yet is suffering from only moderate depression, you have the child's natural resilience to thank. When your doctor does a mental health evaluation of your child, he or she should be noting all the child's strengths that keep those risk factors from taking full control of the child's well-being. Those strengths add up to resilience, and resilience exerts strong protection. Make sure your child knows how resilient he or she is. It will give him or her confidence to deal with any disorder the doctor has diagnosed.

Emphasizing your child's strengths now will also keep you from starting on a wholly negative course that focuses on your child's weaknesses, problems, and deficits.

Much of a mental health evaluation focuses on what is wrong with your child. You'll hear about how poorly he or she is doing in school, what diagnoses apply, the trouble he or she has caused with other children, an inability to ready, difficulties with other children, or any of the many other problems that plague children with psychological problems. Hearing "bad news" is a necessary evil of a good mental health evaluation. But all this "bad news" can take its toll on you and on your child, who, depending on age and intelligence, may begin to see him- or herself as defined by the psychological problems.

Both you and your child should know that sometimes a strength can literally overcome a disability. Tell your son or daughter about Chuck, whose reading disability dragged down his grades and frustrated his parents. Testing found an impaired ability to correctly sound out written words. But he had an above-average ability to recognize the visual shapes of letters and words and connect them with meaning. After discovering this pattern of strength and weakness, I advised his teacher to change her method of teaching Chuck from a method that emphasized word sounds to one that emphasized the visual shapes of words. This new approach dramatically improved Chuck's reading ability. We used a mental strength to compensate for a mental illness.

For other children, there may be no one-to-one link between a weak ability that causes a problem and a strong ability that corrects the problem. But even these children will have strong points that parents should use to make their children feel good about themselves. Billy does poorly in school but shines on the ball field. Sarah misbehaves at home but gets good grades. Jake is fearful of many situations but is a talented musician. Donna reads poorly but excels in math.

Your son or daughter is not "an ADHD child" or a "bipolar child." He or she is a child who has ADHD or bipolar disorder or some other problem, the same way he has black hair or blue eyes, a killer fastball or perfect pitch. Psychiatric disorders are just problems, and to a great extent they can be solved. Turn to the next chapter to learn about the methods we use to solve them.

Chapter 11

Following Up on the Diagnosis

Finding the Right Treatment for Your Child

Once your child has been diagnosed, the practitioner will recommend a treatment plan that will, to whatever extent possible, eliminate the problems caused by the diagnosed disorder and return the child to normal functioning. The best treatment program for your child will be based on everything known about your child as well as a thorough, up-to-date, scientific understanding of what works for which problems. As a parent, it's your job to make sure that all the pertinent facts have been integrated into planning your child's treatment so that the regimen has the best possible chance of helping him or her. This chapter will help you determine whether the treatment proposed for your child is the best route. Then it will describe the most common, most effective forms of treatment for childhood psychiatric disorders available today so that you know what to expect from the interventions chosen for your son or daughter. But your job doesn't end there. Because you are in the best position to observe your child from day to day, you will play a vital role in monitoring your child's treatment once it's under way. I'll tell you how to handle that task so that, whatever treatment is provided, your child gets the greatest possible benefit from it.

Before you launch into this phase of helping your child, however, there are certain overarching principles that can make you an effective advocate for your child and manager of his or her care.

A FEW PRINCIPLES TO GUIDE YOU THROUGH YOUR CHILD'S TREATMENT

1. ***Treatment should flow from*** **all** ***the findings of the mental health evaluation.*** Choosing the most effective, safest treatment for a particular disorder will of course be the foundation of any treatment plan. But a careful practitioner will also consider the child's physical condition, intellectual abilities, temperament and personality, family dynamics, stressors at home and at school, activity schedule, personal strengths, and anything else that might help the child get the most from a proven treatment. The foundation of treatment for ADHD, for example, is generally a stimulant medication, and in the most straightforward cases a prescription from the pediatrician may be all your child needs. But a thorough practitioner will have collected information about how much disruption your child's hyperactivity and impulsivity are causing at home and at school and will use that information to decide whether to recommend behavior therapy as well. The family assessment should have told the practitioner whether you have the resources to apply behavior management principles at home and if the child's teacher would be cooperative. Extracurricular activities and homework may require continuing medication after school, but will the stimulant keep your child awake at bedtime? All these factors should be integrated into decisions about dosage and administration of medication. Details of your child's academic performance plus the results of any psychological testing might indicate whether your child could use the boost of educational accommodations while you're waiting for the medication to have its full effect on your child's ability to pay attention in the classroom. Maybe your child has a superior memory for visually presented material; treatment could include accommodations that would take advantage of that strength, not only improving the child's academic success but giving his or her self-esteem a lift as well.

These are just examples of how all the information that was collected painstakingly during your child's mental health evaluation can and should be used to his or her advantage during treatment. If you believe that relevant facts have been omitted from the plan, be sure to bring this up with the practitioner.

2. ***There is no set sequence of steps by which treatment should***

proceed for all children. A practitioner who has synthesized all the information gathered through the evaluation may have discovered very good reasons for changing the order in which treatments are usually tried, starting behavior therapy for ADHD first, for example, even though for most children with ADHD it would make sense to begin with stimulant medication. If you don't understand the rationale, ask. And keep in mind that treatment for psychiatric disorders is always a matter of trial and error. Sometimes the first treatment approach does not work. If medication is recommended, it might take some time to determine the correct medication and the correct dose. Sometimes the doctor must change a plan of action due to reactions to treatment. A pediatrician might find that a chosen medication may cause intolerable side effects, or a psychologist might find that due to low teacher cooperation, a school-based behavior therapy program will not work. In some cases, psychological therapy may not be a good idea at the outset of treatment but may be reasonable at a later stage. For example, some depressed teenagers are too impaired by their depression to benefit from cognitive-behavioral therapy. In many such cases, use of an antidepressant for a month or two will relieve enough of the depression to make cognitive-behavioral therapy possible. Be patient, expect changes in treatment plans, and monitor your child carefully during treatment trials to ensure a quick arrival at the best outcome.

3. ***Expectations for improvement must be realistic.*** This may seem obvious, but many parents end up expecting much more than they should from their child's treatment. Read the section on outcome in the Part II chapters that cover your child's disorders and then talk to the practitioner about what kind of improvement you might expect given the particulars of your child's condition. Sometimes treatment for a psychiatric disorder leads to a nearly complete "cure." For example, most phobias can be treated successfully. In other cases, treatment eliminates symptoms to such a great degree that the impairment caused by the disorder mostly disappears. In some cases, treatment leads to improvement in some symptoms but not others. Then there are disorders that often remit or subside with maturation, meaning that treatment can help the child cope while impairment is at its peak and may be unnecessary once the child reaches a certain age.

The most you should realistically expect from any mental health treatment is that it will put the child back on the developmental pathway he or she would have been on without the disorder. A child diagnosed with dyslexia may make huge academic strides once taught ways to compensate for this learning disability, but he or she probably won't suddenly become an honor student if psychological tests have shown that the child's IQ is below average. If the treatment normalizes the child in the domains of daily functioning, the treatment has done its job.

4. ***Goals for treatment should always be established.*** If you have any doubts about what kind of improvement you can expect your child to get from treatment, be sure to ask the doctor to spell it out. In fact, short- and long-term goals for treatment should always be set before the regimen is put into place. This will not only keep everyone's eye on realistic expectations but will give you benchmarks by which to measure your child's progress. If the doctor seems to want to remain vague about what can be accomplished, try stimulating progress toward goal setting by saying things like "I'd like to see Johnny get a B in reading by the end of this semester—do you think that's realistic?" or "By the winter holiday break, I'd like Susan to start being able to invite friends over again. Will this plan head her in that direction?"

5. ***It may take time to see improvement.*** When you set treatment goals with the practitioner, make sure you put a time frame around them. Many psychiatric medications take several weeks to produce their full effect and even a couple of weeks to produce any benefit at all. Psychological therapies may take even longer, or the benefits may not extend to all of your child's problems. Your child has a history of behavior that has been learned over time; it will take time to unlearn it as well. Hang in there. Discuss ahead of time with the doctor how long you will tolerate predictable adverse effects of medication while waiting for positive effects to take hold. Ask for a list of the signs that impairment is worsening rapidly and it's time to try a new treatment.

HOW TO EVALUATE A PROPOSED TREATMENT PLAN

First apply the preceding principles. Next, check the treatment sections in the relevant Part II chapters. If the treatments the practi-

tioner proposes are high on the list of proven, effective treatments, you have already formed a mutually trusting relationship with the doctor, and you have no other immediate objections to these recommendations, you may want to approve the plan right then. Keep in mind, though, that new treatments are being developed all the time. To find out about effective treatments developed since this book was written, do some research of your own. Most associations dedicated to educating and informing the public about your child's disorder are good sources of information, and so are many of the major support groups, such as Children and Adults with Attention Deficit Disorders (CHADD) for ADHD. Be aware, however, that some sites aimed at parents include empirical evidence and some do not. Look for mentions of research studies published in well-known scientific journals to be sure there is solid evidence of the efficacy and safety of any treatment you read about. One of the best overall sources of information on childhood psychiatric treatment is, of course, the National Institute of Mental Health (www.nimh.nih.gov).

If the practitioner's proposal deviates from the interventions listed in Part II of this book or you have any other doubts about it, ask if the treatment being recommended is scientifically proven.

If the answer is yes, ask these follow-up questions:

1. How many studies have been conducted?
2. In these studies, what percentage of treated and untreated children showed a good response?
3. What percentage showed adverse side effects?
4. Were these studies double-blind, randomized clinical trials (see sidebar)?
5. Have the results been published in reputable scientific journals?

If the answer is no, ask these follow-up questions:

1. Why do you recommend this treatment?
2. What is the evidence base for this therapy? Your personal experience, written case reports in the clinical literature, or a consensus conference among experts?

The practitioner's answers to these questions will tell you whether—and to what degree—the recommended treatment is clinically proven, meaning that the therapy has been tried in clinics and observed to work even though it has not been studied with scientific methods. Because these clinical observations are informal and lack scientific rigor, we cannot say for sure that the treatment is effective. But if many clinicians make similar observations, then the therapy can be said to be clinically proven. As for scientifically proven therapies, there are degrees of proof for clinically proven therapies, from thousands of clinicians having observed many thousands of children do well on the therapy to your doctor's having invented a new psychological therapy that has been used on only 10 children, 3 of whom improved.

I cannot give you any simple rule of thumb for deciding when it is OK to use a clinically proven therapy beyond saying that you need to be sure that no scientifically proven therapy is available and would be a better alternative. Some disorders, such as bipolar disorder, are so severe that doctors consider it unethical to enroll children in a research protocol that might require them not to have treatment for a period of time. For these disorders, it makes sense to give everybody the best therapy available even if it is not proven scientifically. In these cases, "best therapy" is determined by what has been proven by clinical experience.

One good way to determine whether a clinically proven therapy is justified is to see if it has been endorsed by a consensus of qualified doctors (see sidebar).

How a Treatment Becomes Scientifically Proven

For a therapy to qualify as scientifically proven it must have been tested in one or more research projects that compared the effects of the therapy with the effects of no treatment. Ideally, these studies would use a method known as the *double-blind, randomized clinical trial, double-blind* meaning that neither the patient nor the scientists knew which treatment the patient received, and *randomized* meaning that patients were assigned to the treatment or no-treatment group based on the flip of a coin so that the groups did not differ systematically in some way that might bias the results. The results of these projects should have been published in reputable scientific journals. The latter requirement is important because it assures the study was done correctly.

How to Find Out Whether a Treatment Is Considered Clinically Proven by Consensus

You can learn about these endorsements in several ways. The National Institute of Mental Health (NIMH) is the U.S. government agency responsible for funding most mental health research in America. NIMH periodically convenes consensus conferences in which top clinicians and researchers are brought together to describe the state of the art for diagnosis and treatment of specific mental disorders. If a consensus conference endorses a treatment, it is likely to be a good one. You can find information about NIMH consensus conferences at their website (www.nimh.nih.gov). Another source of professional consensus can be found in the practice guidelines of professional organizations such as the American Psychological Association (www.apa.org), the American Academy of Child and Adolescent Psychiatry (www.aacap.org) and the American Academy of Pediatrics (www.aap.org).

What If the Proven Treatment Is Not an Option?

Which therapy is most effective is, unfortunately, not the only important criterion for choosing a treatment. Drugs known as serotonin reuptake inhibitors, for example, have been scientifically proven to help depression in children, but some children have an adverse reaction to them. If your child is among them—or if the practitioner believes your child may be susceptible to these side effects—a less effective therapy will have to be chosen. This is when you look for one backed by a lot of clinical evidence. If, however, all scientifically and clinically proven therapies have been eliminated from consideration (because they might do more harm than good to your child or for other reasons), or they have all been tried and failed to help your child, or they have been helpful but far from 100% effective, you and the practitioner might consider an experimental therapy. Experimental therapies are just now being studied by scientists. One good reason to study a therapy in children would be if it had been scientifically proven in adults. Another would be a reasonable theory about what causes the disorder, because theories of causality usually have implications for therapy. For example, if scientific evidence leads me to believe that ADHD symptoms are caused by not enough dopamine in the brain's striatum, it would be reasonable to experiment with a treatment that increases dopamine in that part of the brain.

To make the best decision, you need to ask the doctor about the

costs and benefits of the proven therapies and the experimental one: Are scientifically or clinically proven therapies available? If so, is the experimental therapy expected to be much better? What are the drawbacks of the proven therapies? Does the experimental therapy carry the risk for side effects? If your child does well on the experimental therapy, can he or she continue to receive it after the experiment is over?

Sometimes you may be aware of a treatment that your doctor has never mentioned. Maybe you heard about it on the TV news, read about it in a magazine, or heard about it from a friend. In that case, your best bet is to ask the doctor if he or she has heard of the therapy and if there is any reason to think it is worthwhile. If the doctor is dismissive but you want to see if the treatment is worth looking into, search for references to the therapy on PubMed at www.ncbi.nlm.nih.gov/entrez/query.fcgi. But if the media report didn't mention any testing or publication of research studies in scientific journals, it's possible that you've encountered a fad therapy, and it's definitely worth dismissing. Sometimes these therapies seem to make sense. For example, several years ago some argued that disruptive behavior was caused by eating too much sugar. Although never proven, many parents changed their children's diets. Eliminating highly sugared foods from a child's diet is probably a good idea, but it can be harmful to the child if the low-sugar therapy delays effective treatment.

If you can't get an endorsement of a newly touted therapy from a professional you trust, and you can't find any mention of either scientific or clinical proof of it or of ongoing study of it, consider it a fad and drop it. But continue to check your sources to see if the theory ends up being tested in the future.

WHAT TYPES OF THERAPIES ARE AVAILABLE?

The treatment your child's doctor proposes will use medicine, psychological therapy, or some combination of the two. When doctors prescribe medicine for a psychological disorder, they are trying to correct the types of chemical imbalances you read about in Chapter 3. These medicines seek to correct problems with thoughts, feelings

or behavior by correcting the chemistry of the brain. Psychological treatments also attempt to change thoughts, feelings, or behavior, but they do this by having a therapist talk to the patients or their parents or by having them engage in therapeutic activities. For many children, doctors will recommend both medical and psychological treatment because each can be very effective in helping with different aspects of your child's problems. Sometimes medication is aimed at improving the core symptoms of a disorder while psychological therapies address residual disabilities such as social problems or specific problems with daily functioning, many of which have arisen as part of the impairment caused by the disorder. If you are offered only one type of treatment, ask the doctor if adding the other type might be helpful to your child.

My goal in this section is to answer the most frequently asked questions about medications and to give you a feel for how some of the most widely used and most effective of the scientifically proven psychological therapies work, so you will have an idea of what you and your child might be in for if you pursue these interventions. This book can't possibly discuss all the treatments that might be prescribed for your child and might be helpful, but you can get an idea of whether any other treatment proposed for your child is valid by following the guidelines given so far in this chapter.

Although doctors who use drug therapy expect the drugs will affect psychological aspects of the patient's life, these are indirect effects caused by changes in the brain's biology. In contrast, the psychological therapies each target a different psychological domain of life. Parent management training targets behavior. Cognitive-behavioral therapy targets maladaptive thought patterns. Social skills therapies target skills of social interaction. Interpersonal therapies target relationships. Be sure you have a clear understanding of what the

> This chapter uses the term *psychological therapy* throughout, to distinguish this widely varying group of treatments from medication. You may have noticed that this list does not include "psychotherapy." You may hear practitioners and others use the terms *psychotherapy* and *psychosocial therapy* to mean the same thing. I've avoided the word *psychotherapy* because it has been used in so many different ways, both correct and incorrect, that it is no longer useful.

therapy your practitioner recommends involves and how it is expected to help your child before beginning treatment.

Medicine for Psychological Disorders

Thanks to much misinformation and myth, the use of medicine to treat psychological disorders is probably the most misunderstood and controversial area of psychology and psychiatry. Inflammatory reports asking whether it's right to "drug our children" have alarmed many parents, to the point of deterring them from accepting safe, proven treatments that could help their child. Some parents end up believing that medications as a group do more harm than good where children are concerned. Others reject medication because they believe it is a "chemical straitjacket" that controls behavior without solving "the real problem." Of course it's never right to prescribe a medication for a child without careful thought following a thorough mental health evaluation. It's also possible that in today's health care milieu prescribing a medication just to see if it helps may be seen as a time-saving, cost-effective intervention by some physicians. The best way to guard against buying into myths that could exclude your child from the treatment that he or she needs or accepting less-than-optimal diagnostic and treatment approaches is to become fully informed, starting with the following pages. There are also many authoritative sources of more detailed information, which I'll refer to in the next sections.

Table 11.1 shows the most common medications used to treat psychiatric disorders in children today, with both generic and brand names, typical preparations, and the disorders for which they are often prescribed. Additional medications are always being developed and researched for use with children; this list was current as of the printing of this book.

How Do Psychiatric Medicines Work?

As Chapter 3 explained, all psychological activity is a reflection of brain activity, which means that altering the pathways in the brain that produce psychological problems should theoretically eliminate or reduce those problems. Much research and clinical observation

TABLE 11.1. Common Medications Used for the Treatment of Childhood Emotional and Behavioral Disorders

Generic medication name	Brand name
Stimulants	
methylphenidate	Ritalin, Concerta, Metadate, Ritalin LA, Focalin
dextroamphetamine	Dexedrine
pemoline	Pemoline, Cylert
mixed amphetamine salts	Adderall, Adderall XR
Norepinephrine reuptake inhibitors	
atomoxetine	Strattera
Antihypertensives	
clonidine	Catapres
guanfacine	Tenex
propranolol	Inderal
Antidepressants (serotonin reuptake inhibitors)	
fluoxetine	Prozac
sertraline	Zoloft
fluvoxamine	Luvox
citalopram	Celexa
paroxetine	Paxil
Antidepressants (tricyclics)	
desipramine	Norpramin, Pertofrane
nortriptyline	Pamelor
imipramine	Tofranil
amitriptyline	Elavil
protriptyline	Vivactyl
maprotiline	Ludiomil
clomipramine	Anafranil
Antidepressants (atypicals)	
venlafaxine	Effexor
trazodone	Desyrel

(*continued*)

TABLE 11.1 (*continued*)

Generic medication name	Brand name
Antidepressants (atypicals) (*continued*)	
nefazodone	Serzone
bupropion	Wellbutrin
mirtazapine	Remeron
Antipsychotics (typical)	
haloperidol	Haldol
pimozide	Orap
fluphenazine	Prolixin
trifluoperazine	Stelazine
perphenazine	Trilafon
thiothixene	Navane
loxapine	Loxitane
molindone	Moban
mesoridazine	Serentil
thioridazine	Mellaril
chlorpromazine	Thorazine
Antipsychotics (atypical)	
risperidone	Risperdal
clozapine	Clozaril
quetiapine	Seroquel
ziprasidone	Geodon
olanzapine	Zyprexa
Mood stabilizers	
lithium salts	Lithobid, Lithonate, Lithotabs, Eskalith
carbamazepine	Tegretol
valproic acid	Depakene
valproate sodium	Depacon
gabapentin	Neurontin
lamotrigine	Lamictal
topiramate	Topamax
tiagabine	Gabitril

TABLE 11.1 (*continued*)

Generic medication name	Brand name
Antianxiety medications	
Antihistamines	
diphenhydramine	Benadryl
hydroxyzine	Vistaril, Atarax
Benzodiazepines	
clonazepam	Klonopin
alprazolam	Xanax
triazolam	Halcion
lorazepam	Ativan
oxazepam	Serax
diazepam	Valium
clorazepate	Tranxene
chlordiazepoxide	Librium
Atypical	
buspirone	Buspar

Note. Based on T. E. Wilens, *Straight Talk about Psychiatric Medications for Kids*. New York: Guilford Press, 1999.

has shown this to be the case in children as well as in adults, although most psychiatric medicines were first developed for use in adults.

In fact, the biological view of psychological problems has driven the development of medicines for most psychological disorders of childhood in the last few decades. In the early stages of biological research, however, many medicines were discovered by accident. Then, by studying their actions in the brain, scientists learned how they changed the brain in a way that helps children with psychological problems. In 1937, for example, Dr. Charles Bradley was studying children he described as having behavior disorders, many of whom probably had ADHD, a term not in use then. Because the medical procedure he used for his study caused headaches, he tried to treat the headaches with a drug called Benzedrine. Benzedrine did not help the headaches, but later that day teachers in the hospital's school told Dr. Bradley that the children given Benzedrine were

much better behaved and more attentive to their schoolwork than they had been in the past. Benzedrine did not cure headaches, but it alleviated many ADHD symptoms.

Benzedrine belongs to a class of medicines known as stimulants, which also includes methylphenidate and amphetamine. Years after Dr. Bradley discovered that stimulants help children with ADHD, scientists figured out why.

As you may recall from Chapter 3, brain cells signal one another using chemical messengers. If the chemical messenger stays in the gap between cells, the signal will not stop. So the brain has evolved several methods for stopping signals. One method is the use of a very small protein called a transporter because it transports the chemical messengers from the gap back into cell A. Think of the transporter as a little vacuum cleaner that cleans the gap between nerve cells, ends the signal, and, in doing so, prepares the gap for the next signal. There are several types of transporters, one for each type of chemical message. The serotonin transporter cleans serotonin from the gap. The norepinephrine transporter vacuums norepinephrine and the dopamine transporter vacuums dopamine.

Recent research suggests that children with ADHD have too many dopamine transporters in a small area of the brain called the striatum. When there are too many transporters, the chemical message sent by dopamine is vacuumed up too quickly. This interferes with the messages that dopamine cells are trying to send to one another. Because we know from both animal and human studies that the striatum helps regulate attention, motor behavior, and impulsivity, it makes sense to think that problems with the striatum could lead to ADHD signs and symptoms. If this is true, then a medicine that reduces the number of dopamine transporters in the striatum should help ADHD children. And that is exactly how stimulants work. After a child with ADHD takes stimulant medication, the medicine finds its way to the brain's striatum. When it gets there, the medicine stops the action of some of the dopamine transporters. As a result, the gap between nerve cells is not cleaned out so quickly, the signaling between cells is improved, and ADHD signs and symptoms also improve.

It's important to understand that scientists have made huge strides toward understanding exactly what parts of the brain are af-

fected by which medications and what psychological activities are governed by those parts of the brain. The medicines we have available today target specific chemical imbalances and thus improve specific symptoms. They are not the so-called chemical straitjackets so notorious in times past. During the 19th and early 20th century the only way to treat serious mental illnesses was to use tranquilizing medicines to calm violent patients or relieve others from the distress of severe anxiety or depression. Today we have a wealth of medicines that actually alleviate those symptoms; chemical straitjackets are an unnecessary relic of the past.

Myths like that of the chemical straitjacket persist in part because parents are vigilant to any perceived threat to their child, and, unfortunately, the media often play into these fears. The rest of this section, therefore, is organized around the most common concerns parents have brought to me about use of psychiatric medicines in children.

Are Psychiatric Medications Safe?

There are many aspects of safety to be considered, from probability of side effects to drug interactions to long-term effects on children's development.

- *Don't psychiatric medicines have adverse side effects?* When you're considering the use of psychiatric medicines for your child, you will need to carefully balance the benefits of the medicine against its potential for adverse side effects. You should first understand one point. You may have read in a magazine or heard on TV that psychiatric medicines cause irreversible brain damage to children. This claim is simply not true. Such claims are usually based on studies of animals that have used extremely high doses of medicine, sometimes hundreds of times greater than would be used in the treatment of children. You may have also heard claims that psychiatric medicines have caused suicides or violent behavior. People making such claims have typically confused the effects of the disorder with the effects of the medicine treating the disorder.

Although we can cast aside these extreme claims about adverse effects of psychiatric medicines, you should be aware that most medi-

cines carry some risk for adverse effects. The nature of these effects will differ from medicine to medicine. Many are minor, such as either difficulty sleeping or sedation from some antidepressants and loss of appetite from stimulants. Most can be managed with a change of dose, by switching to a new medicine, or even by adding another medicine. But other side effects are serious, even if rare. For example, the antipsychotic clozaril can sometimes cause a deadly disease called agranulocytosis. Other antipsychotics can cause irreversible abnormal movements. Medicines with such serious side effects should be used only as a last resort. If used, your doctor should closely monitor your child's condition.

To learn about potential side effects, ask your doctor and your pharmacist. You can read the written information provided with the medicine and consult the *Physicians' Desk Reference* (available at all libraries). The trouble with these sources is that they list all side effects with little perspective for you on how common they are or how truly serious. Reading a long list of all side effects ever reported can be unduly alarming. A better choice might be one of the excellent books that describe these medicines in detail, such as *Straight Talk about Psychiatric Medications for Kids* by my colleague Timothy E. Wilens, MD (Guilford, 1999). Also check the National Institute of Mental Health website mentioned earlier (www.nih.nimh.gov), along with the website for the American Academy of Child and Adolescent Psychiatry: www.aacap.org.

Although serious side effects are rare, their possibility makes some parents ask whether medicine should be given to their kids at all. The only way to answer that question is to weigh the risks of the medicine against the alternative. If the child does not take this medicine, are there other treatments that will help as much, or will it mean not treating the child at all? What seems likely to hurt your child more, risking certain fairly mild side effects or living with the impairments that urged you to seek treatment for your child in the first place? Also, remember that judging a psychiatric medicine on this basis is no different from judging the risk of a painkiller or antibiotic prescribed for a medical condition.

• *When I asked my daughter's doctor if the medication he wanted to prescribe was approved by the FDA, he said it wasn't but that he thought it was safe. How can I be sure?* In the United States,

before a drug can be used in patients, the company that created the drug must prove to the U.S. Food and Drug Administration (FDA), through a series of rigorous scientific studies, that the drug is safe and effective for treating a specific disorder. The specific problem for which the FDA has approved the drug is then clearly spelled out on the insert that the company must enclose with the drug when it is sold. The insert clearly indicates for what doses, ages, and disorders the drug has been approved.

A medication your doctor prescribes for your child may deviate from these specifications, but that doesn't mean it's not safe. Such "off label" use of psychiatric medicine for children is fairly common. Your doctor will probably tell you that, although the FDA has not approved the use of the medicine for your child's situation, he or she believes from either clinical experience or reading the research literature that the medicine will be safe and effective for your child. In other words, although your doctor may be prescribing outside of the FDA guidelines, he or she will be prescribing inside the clinical guidelines of child psychiatry.

The SSRIs, antidepressants like Prozac and Zoloft, for example, were originally studied and approved for treating depression in adults, but since then doctors treating depressed children and adolescents have shown that the SSRIs also help youth with depression (and youth with obsessive–compulsive disorder). Therefore these drugs are now considered safe for children even though they do not have specific FDA approval for use in children. Although the companies that sell these medicines could seek FDA approval for these uses in children, they have not because doing so would be very expensive. Fortunately, the FDA allows "off label" uses of medications to ensure that appropriate uses discovered after the initial approval are possible.

- *Are psychiatric medicines safe for very young children?* This is a tough question to answer across the board. Most of the research on psychiatric medicines in children has studied school-age children, which means that positive evidence for use in preschoolers is clinical, not scientific, proof (though studies are currently under way). Also, some have questioned whether the still-developing brain of very young children can be harmed by these medications. Although the facts needed to answer such questions are now being collected by cli-

nicians and scientists, parents who must face this issue today naturally are concerned.

If you are faced with this issue, ask why the doctor thinks the medicine will be helpful, what the doctor's experience has been using this medicine in other young children with the same disorder, what treatment alternatives are available, and what the consequences of not treating with medicine would be. This last question may be the most important. Suppose a parent decides to wait a year before medicating a 3-year-old for what the doctor views as a serious case of bipolar disorder, which has clearly interfered with the child's ability to make friendships and have normal relationships with family members. The parent's rationale is that, despite the doctor's opinion, it is possible that the child will outgrow the problems. The rationale resonates with common sense, but if the doctor is correct, the parent will have added 1 year of distress and disability to the child's life. That one year is one fourth of the 4-year-old child's life. So from this perspective, delaying treatment for this 3-year-old is equivalent to having a 30-year-old wait 10 years.

Making your child wait for medical treatment does not make sense if he or she has a seriously impairing disorder for which effective medicines are available. But waiting can make sense in some circumstances. If the disorder is mild and not interfering much with your child's day-to-day life, your doctor might agree that medicine is not needed. In such cases a psychosocial treatment will probably be suggested. Or if the disorder is of recent onset in response to a clear change in the environment such as the family moving or divorce of the parents, the doctor might suggest another mode of therapy. In either case, you should monitor your child's symptoms. If they are not getting better or are worsening, you and your child's doctor may want to reconsider treatment with medicine.

- *Will using these medicines encourage my child to abuse drugs?* Some parents worry that taking psychiatric medicines will teach their children to use drugs as a crutch to get through life instead of learning to deal with life's problems on their own. They reason that this learning experience will make them more susceptible to using illegal drugs in the future. *There is no scientific evidence that the appropriate use of psychiatric medicines leads to drug abuse.* In fact, as you have read in Chapter 4, the appropriate use of psychiatric medicine

may protect children against drug abuse. Counteracting the impulsivity of ADHD with medication may discourage a teenager from trying street drugs, and reducing a child's distress due to fears, nervousness, or depression may prevent the child from trying to self-medicate with alcohol or drugs.

Unfortunately, the myth that psychiatric medicines cause drug abuse seems to persist in part because of misunderstandings about the difference between drugs of abuse and psychiatric medicines. Street drugs provide some pleasurable feeling, whereas psychiatric medicines simply correct a psychological symptom—there is no "high" involved. The media, however, continue to report on the rare instances of psychiatric medicines, particularly the stimulants used to treat ADHD, being abused by being taken in very large doses. If you are concerned about this possibility, know that there are many ways to prevent it. For example, long-acting formulations of stimulants need not be taken to school and are difficult to grind into a powder that can be snorted through the nose. There are also nonstimulant alternatives for ADHD. Ask your doctor about any abuse potential of a medication being prescribed for your child; the risk is almost always low, and there is almost always a viable alternative.

What Are We Getting Ourselves Into?

Many parents worry about how long their child will have to take medication, how it might interact with other medications the child may have to take in the future, and whether the first prescription will be the right one.

- *Will my child need to take medication for his or her entire life?*

As a rule of thumb, the more serious the disorder, the more likely it is that your child will need a long course of treatment. Some children will need treatment through adulthood. Children with severe mood disorders, for example, are likely to need treatment for a long time. Some may always need medication. Others may need it intermittently. In contrast, the psychological treatments for phobias can often teach phobic patients to master their fears and live normal lives without medicine. ADHD can be a lifelong disorder, but about 15% of children will no longer need treatment in midadolescence. We know

less about the course into adulthood, but available studies suggest that about 30% of ADHD children will not need treatment into adulthood. You and your doctor will be monitoring your child on a regular basis to assess your child's symptoms and level of impairment and make decisions about whether to cut back or stop treatment altogether as the child improves.

• *Will this medicine work for my child for as long as he or she needs it?* Not necessarily. Because children are developing, and you can't predict the exact course of your child's disorder, your child may need more or less medication or even a different one at some point down the road. In some cases children develop a tolerance to a medication or the dosage and need to alter their prescription to get the same treatment effect. But you should also be prepared for the definite possibility that the first medication prescribed won't prove effective. That's why practitioners refer to treatment with any medication as a "trial." In some cases the doctor may need to try several medicines before finding the correct one. Often several medications are equally effective in treating a particular disorder, but they won't necessarily treat any individual child equally. Nor will all children tolerate the same side effects equally. With ADHD, for example, a doctor might start by trying methylphenidate, but if the child doesn't tolerate it well or it doesn't improve the symptoms substantially, the doctor might suggest trying the equally effective amphetamine instead. A third choice, atomoxetine, should be available by the time this book is published. The point is that you shouldn't get discouraged if your child has to go through several drug trials before the doctor finds the best medication and dose. Nor should you assume that your child is "getting worse" if the dosage is increased or a medication changed in the future.

• *What happens if my child needs to take more than one medication?* If your child has more than one disorder, he or she may end up with more than one medication. In that case it will be up to the prescribing physician to protect the child against potential drug interactions. Some drugs do change the action of another when they are taken simultaneously. They might increase another drug's effect, decrease it, or alter it in some other way. Many drug interactions are nil or minor, but some can be very dangerous. Adding Prozac to medicines known as MAO inhibitors can cause a fatal reaction preceded

by nausea and vomiting, high blood pressure, and shock. Your doctor will inform you of any possible such interactions, and if he or she doesn't, ask.

Your child might also end up taking another medication prescribed by a different doctor, such as for a medical condition like asthma. *Always tell any physician who is about to write a prescription for your child about all medicines your child is already taking, both prescription and over the counter.* Even natural or herbal treatments sold in health food stores can have unforeseen interactions with medications. Also read the information enclosed with any medicine your child is starting to take. Try to make a habit of using only one pharmacy to fill your child's prescriptions. Pharmacists know a good deal about the biological properties of medicines and how they interact with each other. If you use only one pharmacy, your pharmacist will know all the medicines your child uses, which will make it easy for him or her to detect potential problems.

- *If my child is taking a medication to improve his or her behavior and success at school, can he or she stop taking the medication on weekends and during school vacations?* Parents often like the idea of keeping the total amount of medicine their children need to take to a minimum and therefore ask if a child can take a "medication holiday" at times when the effects of the medication may be needed less. For most medicines, weekend vacations are not possible because the medicine does not immediately leave the child's bloodstream the day she stops taking the medicine. The weekend medicine vacation was once popular for children with ADHD taking stimulants because these medicines must be taken daily to stay in the child's bloodstream and doctors thought ADHD was primarily a school-based disorder. But today we know that ADHD does not turn itself off on the weekend, so weekend medicine vacations are not a good idea unless you have a concern about side effects or you are sure your child's ADHD does not seriously affect him or her during the weekend.

The same logic applies to stopping psychiatric medicines during school vacations. Some parents might even be tempted to stop an antidepressant, but you should do this only if you and the doctor agree that your child has recovered thoroughly enough—or outgrown the disorder. If your child has been treated for a while and is doing very well, your doctor might decide a medication holiday would be useful

to determine whether the recovery can be maintained without treatment. In that case, choose a time when the demands of life are less stressful than usual, such as summertime or the middle of a relatively unchallenging semester (not right before final exams). You should also be on hand to monitor the child while off the medication (not while the child is at camp and you are at home) so that the medication can be restarted quickly if needed.

How Expensive Will Medications Be?

Chapter 12 explains in more detail how mental health care costs, including prescription medications, are usually covered by insurance plans. But most parents want to know what types of money-saving choices they will have and how their decisions will affect their child.

- *Are psychiatric medicines covered by health insurance?* Some plans cover most, if not all, psychiatric medicines, while others cover only some, and some provide no coverage at all. If your coverage is poor, you might consider changing plans, especially if your doctor expects your child to need an expensive medicine for a long period of time. The important point to understand about medication coverage is that many insurance plans require doctors to prescribe less expensive medicines. In these plans, doctors must prescribe generic medicines before the identical brand-name. Both medicines are nearly identical, but the brand-name advantage comes with the ability to charge a higher price.

In some plans, they must prescribe an older generic medication before trying a new brand-name even if that brand-name medicine is chemically different from and better than the old generic. For example, because they were more effective and came with fewer side effects, the development of new antidepressants such as Prozac, Zoloft, Effexor, and Wellbutrin was viewed as a boon to those suffering from depression. But because the older tricyclic antidepressants were available as inexpensive generics, some insurance plans would cover the cost of the new antidepressants only if the doctor could document that the tricyclic did not work. You may have very good reasons to prefer one medication over another, but your insurance plan will not agree. Prepare yourself for the possibility that you'll have to go through an appeal process to get the medication that's best for your

child. How difficult this will be may depend in part on your practitioner's willingness to challenge the system with you. For example, maybe your son with ADHD has been doing fine taking generic methylphenidate three times each day, but now that he's entering high school he doesn't want to have to go see the school nurse during the school day for his medicine, so your doctor suggests a version of methylphenidate that lasts through the school day. You and your son like this plan because he would need to take the long-acting version of methylphenidate only once, before going to school. But because long-acting versions of methylphenidate are not available as generics, your health insurance plan may not cover them. Now your son has been skipping his midday dose. Will your doctor support you in appealing to the insurance company, or will he or she say that it's your job as a parent to make sure your son takes the medication? Similarly, will your doctor help you get coverage of a more expensive medication to avoid annoying side effects or to increase your child's benefit from treatment from 75 to 95%? As you can see from these simple examples, your doctor can be an important ally when dealing with such issues. So do the best you can to maintain a friendly and cooperative relationship.

- *Are brand-name medicines better than generic medicines?* If both are the same chemical, it seems logical to choose the less expensive generic over the brand-name, and most insurance companies would agree. But the manufacturer of a generic drug does not have to prove to the FDA that its product is safe and efficacious, only that it has the same chemical structure and biological activity. This means that if quality control procedures are not up to the standards upheld by the brand-name drug's manufacturer, then even if the generic is in theory exactly the same as the brand, in practice it may be a less pure form.

My advice is to ask your doctor and pharmacist about the specific medicine your child has been prescribed. They will have had many years of experience with both the brand and generic and can tell you if there is any practical difference between the two.

Psychological Therapies

Psychological therapies differ from medication therapies in a few significant ways:

- Instead of trying to change pathways in the brain with medicine, the therapist talks to the child or teaches the child various techniques to change behavior. This means that the psychological therapy may involve much more participation from the child than medication therapy, which often involves little more than taking a pill. Many psychological therapies will require a once-a-week appointment with the therapist, plus homework, until the maintenance stage of treatment is reached. Psychological therapy may therefore require a greater commitment on the part of both the child and the parents than medication treatment.
- Psychological therapy may require more time to improve the child's symptoms. Medication can take a month or two to have its full effect, but psychological therapies typically have gradual effects over several months. This is often why practitioners recommend a medication that will start easing the child's symptoms while the child is still building toward improvement with a psychological therapy.
- More and more psychological therapies take a self-help approach that has the child or parent be active participants in the therapy. This will depend largely on the age and abilities of the child and the time and effort the parent is willing to invest, but certain therapies generally lend themselves to self-help. Parent management training is the best example, but there are also very effective techniques that parents can use, once taught by a therapist, to head off episodes of anxiety, to fight depression, and even to loosen the hold of obsessive–compulsive disorder on a child. The public schools may also supply certain forms of psychological therapy, especially in the area of behavior management, at no cost to you (see Chapters 10 and 12 to find out whether your child might qualify for special education services).

Parent Management Training: Using Rewards and Punishments to Control Behavior

Parent management training seeks to directly modify the child's behavior using rewards and punishments managed by the parent. This therapy does not directly target thinking or emotions. Instead, it assumes that healthy changes in thinking and emotion will occur once the problem behavior changes. Parent management training

views the signs and symptoms of psychiatric disorders as learned behaviors.

Parent management training can be used for many disorders. A psychologist would decide to use this approach if some of the problems associated with the disorder appear to be learned. For example, Parent management training could help parents to teach an oppositional child to comply with their requests, to teach a child with ADHD not to climb on furniture, or to teach a child with a phobia not to be afraid of dogs. In each case, the psychologist would give the parent instructions about how to react to the child's behavior in a manner that is most likely to reduce the frequency of the problem behavior.

Parent management training is founded on the principles of reward and punishment. One of the most important laws of human behavior is that whether or not a behavior occurs more than once depends on the nature of the consequence. If the behavior is rewarded, it will be more likely to recur. If it is punished, it will be less likely to recur. Intuitively, all parents know and act on these principles, and for most children using rewards and punishments is straightforward. But when children have psychological problems, help from a behavior therapist may be necessary. Parenting such children presents special challenges. They need a comprehensive and consistent program that is sensitive to their individual needs and the competing demands on the parent's time. Moreover, when a child has a psychological disorder, the behaviors that need to be changed can be very resistant to the everyday application of rewards and punishment. In such cases, behavior therapy can succeed where normal parenting cannot.

Parent management training can take several forms, and experts have developed very specific programs aimed at the challenges posed by particular disorders, such as ADHD and ODD. But the therapy always has four main components: (1) identifying target behaviors, (2) choosing rewards and punishments, (3) defining rules, and (4) making the rules work for you at home.

1. *Identifying target behaviors.* To improve your child's behavior you need to come up with specific target behaviors to discourage—such as, "He starts arguments with his sister almost every day" or "She's late for the school bus at least three times each week" rather

than the global "He's so irritating" or "She never obeys the rules"—or to encourage, such as "playing quietly with his brother," "going to bed on time," or "clearing his dishes from the table without being prompted." Once you've identified possible targets, you should observe your child for a week or two, recording the frequency of target behaviors. This provides you and your therapist with an objective view of the target behavior and the problems it causes. While you are identifying and counting target behaviors, you'll also need your therapist's help to figure out what rewards and punishments will work best for your child to change these behaviors.

2. *Choosing rewards and punishments*. Using your target behaviors, you set behavioral goals (e.g., "Doing your daily chores at least three times each week") and then decide whether you're going to help your child reach each goal by using the "carrot" or the "stick." Most experts today agree that rewards are more effective incentives than punishments. Depending on the goals and the challenges posed by the child's disorder, however, you may want to use rewards to encourage the child to gradually build toward behavior change in some areas (such as doing chores) but use mild punishment (such as time-out) for bad behavior that you want to stop immediately (such as hitting his or her sister).

3. *Defining the rules*. Parent management training depends on consistency, which means that everyone has to understand the rules ahead of time. At this stage you make sure your child understands which behaviors will be rewarded and which punished and exactly what the rewards and punishments will be. For older kids and teens many psychologists will suggest a behavioral contract that states the child's and parents' responsibilities, the behaviors of concern, and the rewards and punishments.

4. *Making the rules work*. Again, consistency and diligence are key. When you see a rule being broken, you have to enforce the consequence. When you notice a positive behavior, you must scrupulously reward it, whether it's just commenting on it for now, recording it on a star chart or other behavior record, or providing some incremental reward like a little trinket, a certain number of which can be turned in for a larger reward (to encourage the child to attain short- and long-term goals). Also important is to avoid getting angry or irritable and to let the rules exact the discipline.

Even children who are very young or severely impaired can improve behavior using this type of program. As necessary, behavioral goals can be extremely simple, or even a simple goal can be broken down into parts that will each be rewarded when reached. A therapist can help you adapt the program to your child's and family's needs.

I strongly encourage all parents to consider applying parent management principles if not an entire formal program. Most kids with psychological problems have a history of troublesome behavior that needs to be unlearned, and this type of program is a relatively simple way to do it at home, often on your own. Books such as *Parents Are Teachers: A Child Management Program*, by Wesley C. Becker; *Complete Early Childhood Behavior Management Guide*, by Kathleen Pullan Watkins and Lucius Durant; *Your Defiant Child*, by Russell A. Barkley, and Christine M. Benton; and *Discipline without Stress, Punishments or Rewards: How Teachers and Parents Promote Responsibility and Learning*, by Marvin L. Marshall, are good sources of information and instruction.

Social Skills Therapy: Acquiring New Behaviors

Through parent management training you can encourage your child to increase the frequency of desirable behaviors and decrease the frequency of undesirable behaviors by the consequences you impose when you observe that behavior. But what if you want your child to develop a behavior that he or she never exhibits at all? For these cases, psychologists have developed a treatment known technically as *response acquisition training* but usually called "social skills training" because the behaviors being trained are mostly social in nature, such as learning how to make friends. Some social skills training programs also include nonsocial behaviors needed to function in everyday life. These can be very simple, such as dressing in the morning, or more complex, such as developing good study skills.

Behavior therapists frequently use social skills training to help children who have difficulties interacting with other children. Many of these children simply lack the skills needed for effective and enjoyable interaction. For example, most kids figure out early on how to join in with a group of children playing together on the playground at

school. Others cannot figure out how to join in and end up playing alone or, worse, they make a bad impression when they try to join in. Children with pervasive developmental disorders almost always need social skills training, but other psychological problems can also stand in the way of children's developing effective social skills, so this therapy can be of use to many different kids.

Therapists use social skills training to teach these kids the behaviors they need to talk and play with other children—how to make friends, start conversations, speak clearly, and tolerate silences and criticism. Using modeling (learning through imitation), they practice facial expressions, greetings, eye contact, and the pacing and intonation of speech, often in a group setting. First the therapist models a skill, then the children practice and the therapist gives the children feedback about their performance. A typical session will repeat the practice and feedback to be sure all the children get it right, letting the more advanced children serve as models for the others.

In addition to practicing skills with the group, the therapist will have the children use them at home, in school, or when visiting friends. By starting with simple situations (such as saying hello to other kids on the playground), the children gain a sense of mastery and eventually can tackle more difficult social interactions (such as asking a peer to visit after school).

Interpersonal Therapy: Learning to Deal with People

Interpersonal therapy (IPT) focuses on the child's current life and relationships with friends, teachers, family, coworkers, and others. The main goal of IPT is to teach children to identify problems in relationships and how to solve these problems. Because IPT requires children to reason and talk about their lives, it is suitable only for older children who do not have problems that impair language or thinking. During therapy sessions, which focus on specific situations and problems in the child's life, an IPT therapist helps the child improve communication skills and feel better about him- or herself. Although IPT does not assume that interpersonal problems cause mental disorders, it does assume that relationships with other people can affect the timing and severity of the signs and symptoms of these disorders. The IPT therapist will focus on three aspects of a patient's social life: conflict with others, key life transitions, and interpersonal deficits.

Conflict with others refers to disputes with parents, siblings, or friends leading to distress and psychological symptoms. For example, a teen's parents may have forbidden him or her to socialize with a favorite friend out of concern that the friend is a bad influence. For such conflicts the therapist will help the teen discover areas of misunderstanding, unrealistic expectations, self-destructive thought patterns, or miscommunication.

Key life transitions are situations that require the child to adapt to new circumstances, such as attending a new school, getting a first job, breaking up with a girlfriend, losing a parent, or moving to a new community. The therapist helps children identify the specific problems arising from such changes and shows them how to find solutions. For example, he would help a shy teenager to make friends in a new school or help another see how his unreasonable thought patterns make it difficult for him to cope with the loss of his girlfriend.

Identifying interpersonal deficits helps the therapist understand what types of social behaviors or attitudes the child needs to learn. This phase of therapy can be similar to social skills training in that it will teach specific skills to children who need them. But it also addresses broader aspects of personality that interfere with social relationships. For example, some children show an excessive need to control others within relationships, yet do not realize that this occurs or that it causes problems. By using examples from the child's life, the therapist helps the child understand such maladaptive attitudes and personality styles.

IPT sessions are held weekly for about 3 or 4 months. Initially the doctor will ask questions to learn about the child's interpersonal life and the psychological problems that brought him or her to therapy. The therapist will make a list of all the important relationships in the child's life and for each relationship will assess the relevance of disputes with others, key life transitions, and interpersonal deficits.

Cognitive-Behavioral Therapy: Using Thoughts to Control Behavior and Emotion

Cognitive means "having to do with thinking," and cognitive therapy brings the child's patterns of thinking into the process of understanding and changing behavior. Whereas parent management training works directly on the child's behavior and assumes that healthy

changes in thinking and feeling will follow, cognitive-behavioral therapy targets the thoughts that precede emotional and behavioral reactions. Cognitive therapists believe that problem behaviors occur when the child has inaccurate thoughts about events in his or her environment. These inaccurate thoughts lead to inappropriate emotions and problem behavior.

Also unlike parent management training, therapists talk directly to the children rather than talking to the parents to help the children. Like IPT, this type of therapy is most appropriate for older children with good verbal skills.

The main challenge of the cognitive therapist is to help the child identify the inaccurate thoughts that set off maladaptive behaviors, especially the automatic thoughts that we all have, which are either fleeting or unconscious but rarely explicit. Consider a child who has had several failure experiences, exacerbated perhaps by peer ridicule or an insensitive teacher, and is vulnerable to anxiety or depression. The child may begin thinking explicitly that he or she is stupid in school or uncoordinated in sports or lacking in musical talent. Then, the next time something does not work out, the child attributes the failure to his or her own shortcomings rather than to some other event. Eventually, that negative thinking becomes engrained in the child's personality and the thoughts become automatic. Thoughts like "I failed because I'm stupid" and "I did well because the test was easy" occur frequently, but the child is barely aware of their existence.

In addition to irrational attributions, cognitive therapists help children identify other types of inaccurate thinking, such as biased attention, which occurs when they overfocus on aspects of events that lead to self-defeating thoughts. The child who dwells on the one friend who did not attend his or her party has discounted the eight others who did attend. Biased recall occurs when children's selective recall supports their distorted self-image. Some children with depression vividly recall small failures yet have a hard time recalling their successes. Some children overgeneralize bad experiences, like the child who was bullied at school by one of his classmates and then feared that others disliked him and would do the same. Some children tend to think in extremes. Friends either love them or hate them. There is no middle ground.

The cognitive therapist ferrets out distorted thinking by having

children talk about their experiences and keep a diary to describe their thoughts when negative emotions or problematic behaviors occur. This helps kids make explicit what has become automatic. During a session, the therapist will ask many questions. If the child says, "My mother made me feel horrible when she introduced me to her new friend," the therapist might ask, "What were you thinking about at that time?"

Once the inaccurate, automatic thoughts are brought to the surface, the therapist can help children to realize that the thoughts are not accurate and cause many problems. This motivates children to change by explicitly changing their style of thinking. In essence, the cognitive therapist teaches children to replace inaccurate self-defeating thoughts with accurate thoughts that help them solve the problems they face in life. Children learn new ways of thinking during therapy sessions and then practice these new strategies between sessions as they go about their daily life.

Cognitive therapy has been most useful for disorders such as depression and anxiety in which maladaptive thoughts and emotions are a main feature. For example, children with depression often have many negative thoughts about themselves ("I'm worthless"), their current life situation ("I'm a terrible student"), and their future ("I'm going nowhere in life"). Adults and children with panic disorder often have irrational thoughts about pending disasters, which to them seem likely (to them) to occur in certain situations.

The ultimate goal of cognitive therapists is to help the client understand his or her style of thinking so that eventually he or she can identify and modify irrational thoughts without the aid of the therapist. Toward this end, therapists will ask clients to work outside sessions to discover maladaptive thinking habits and to try to generate accurate thoughts to replace the inaccurate ones in the real-life situations. These real-life experiences are then used for discussion during therapy sessions. Therapists will also encourage clients to try new behaviors or enter new situations that have previously been avoided.

Systematic Desensitization: Learning through Association

Over 50 years ago the Russian scientist Ivan Pavlov taught us that we can learn by association. Just as Pavlov's dogs learned to salivate

when they heard a bell ring because they had become accustomed to being fed after a bell rang, children can learn or unlearn an emotional response that is harming them. Many years after Pavlov's experiments, behavior therapists applied the principle of learning by association to the treatment of anxiety disorders. Consider the case of a girl who has an intense fear (phobia) of going to school. Pavlov's theory provided both an explanation for the fear and a method of therapy. It was possible that during the school day the girl had experienced some distressing event, which made her upset and fearful. Just as the dog had learned to salivate at the sound of the bell, she had learned to be fearful at the sight of the school. But Pavlov had also discovered that the dog could unlearn the link between the bell and salivation, and behavior therapists discovered they could erase in human beings the link between feared situation and the feeling of fear. The therapy became known as *systematic desensitization*, a procedure whereby the client is gradually reintroduced to the feared situation in a manner that does not lead to a fear response. In other words, the person unlearns the association of the situation with fear and learns to associate the situation with a feeling of relaxation or, at least, not with fear.

Systematic desensitization works by having the child master the easiest situations first and then moving up the hierarchy step by step. Nine-year-old Sarah, for example, was so afraid of heights that she could not sleep in her second-floor bedroom, enter tall buildings, or get on an airplane. To help her, we started with relaxation training, then created a fear hierarchy, which started with her imagining walking over to the stairway and looking up the staircase and then, as she was able to master each step, continued with walking over to the stairs, climbing the stairs, thinking about being in her room, being in her room, thinking about looking out her window, and looking out her window. The therapy included practice at home at each step, using relaxation exercises to drive the nervousness away. For children, it also requires the help of parents.

In difficult cases, the therapist will use modeling during systematic desensitization therapy. If Sarah was able to think about going upstairs but could not bring herself to even walk over to the stairway, we could have had someone who was similar in age and the same sex

and ethnicity climb the stairs while Sarah watched, noting that nothing fearsome happened.

A variation on systematic desensitization is exposure therapy, which is simply desensitization without relaxation training, used when the fears are not too strong so that the patient can think about the fearful situation or be in mildly fearful situations without getting nervous. For example, if Sarah were able to walk over to the stairway without being nervous, exposure therapy would have her stand there for 15 minutes looking at the stairs. Then she would be asked to climb the first step and stand there for 15 minutes. If she were to get nervous, she would be told to step back down and not try the first step again until her nervousness subsided. In my experience, teaching nervous or fearful patients relaxation skills is usually worthwhile but may not be feasible for very young children or those who do not understand the instructions.

Children with obsessive–compulsive disorder are often treated with a therapy called *exposure and response prevention*, during which the child is exposed to the feared situation or idea and prevented from making the response, typically a ritual such as washing repeatedly when exposed to something that he or she thinks will cause contamination with germs. Ideally, relaxation training is also used so that the child learns to be relaxed when faced with the feared situation or idea. Essentially the child is exposed over and over to the object of the obsession and helped, through relaxation training, to tolerate the feelings of discomfort until the anxiety begins to pass. The more he or she does this without giving in to the compulsion to perform some ritual to ease the anxiety, the more the child learns that the situation or idea is not threatening.

Another related term is *flooding*, which is simply systematic desensitization without either relaxation training or the hierarchy. If I had chosen flooding for Sarah, I would have had her parents take her up to her room and have her look out the window. Yes, Sarah would get upset, feel awful, and might even try to escape. But by being forced to face her fear she would learn that nothing bad would happen and would unlearn the fear. Flooding, however, often causes more problems than it solves. For example, Sarah's flooding experience would not make her trust me as a therapist and it could strain

her relationship with her parents. In contrast, systematic desensitization builds a therapeutic relationship and gives patients the feeling that they have mastered their fear.

MONITORING YOUR CHILD'S TREATMENT

As I've mentioned, it's not unusual to have to go through several therapeutic trials before you arrive at a treatment plan that is as close to 100% effective as possible. But you should be concerned if a therapy that doesn't seem to be working yet is continued anyway. To avoid this problem, track the progress of your child through therapy. Some therapists will ask you or your child to provide information on progress each week or two. For example, in parent management training, therapists typically have parents record the occurrence of behaviors they are trying to change. Doctors treating ADHD often ask parents to check off the severity of each ADHD symptom each week. There

Is It OK to Hit My Child?

Learning through association and learning through reward and punishment can occur at the same time. One important example of the two working together explains why behavior therapists do not recommend spanking, yelling, or other very aversive punishments. Imagine a father who tells his child to do his homework. The child then whines, and the father hits the child to stop him. The father thinks that because he punished the whining through hitting he has taught his child not to whine. He is correct. Through reward and punishment learning he will teach the child not to whine. But hitting the child has an unintended effect. Through association learning, it teaches the child to be nervous and fearful around the father. Just as the bell became a signal for food and caused salivation, the father will become a signal for violence, which will cause fear and distress. Eventually, this will create strained relationships in the family and more psychological problems for the child.

If you find yourself hitting your child to control his or her behavior, you and your family may need professional help. Violence toward children is a sign of parental failure, not parental strength. It also teaches children that violence is an acceptable method of problem solving, which often comes back to haunt parents when the child they have hit begins to hit siblings or friends.

are rating scales like those mentioned in Chapter 10 that can be used to assess a child's improvement from week to week during treatment. If your doctor does not provide such a monitoring plan, you should ask how progress will be monitored and if you can help monitor progress at home.

You can also create your own monitoring system as follows. Choose the main five or ten behaviors that your child frequently shows as part of his or her disorder. The list would include behaviors you can observe, such as fighting with siblings, crying frequently, not paying attention, disobeying, being uninterested in eating, sleeping poorly, and being afraid to ride on the school bus. At the end of every week, comparing your child to how he or she was the week before, you can rate each behavior as much worse, somewhat worse, no change, much improved, or very much improved.

If you are not seeing improvement from week to week, ask the doctor if the therapy is still warranted. For some therapies—for example, antidepressants or cognitive-behavioral therapy—change is expected only after about a month of treatment—a fact you will be aware of if goals and time frames have been set. Give the doctor enough time to help your child, but if your child does not improve sufficiently when expected, it may be time to move on to another therapy.

Encouraging Compliance with Treatment

Another way to monitor your child's treatment is to make sure he or she adheres to the regimen. Skipping doses of medicine or missing therapy sessions will only delay improvements. If your child's plan includes therapeutic homework, it's your job to make sure it's done. At first, you may need to use notes as reminders. Even better, get into the habit of spending 5 minutes each morning thinking about what you need to do to help your child's progress.

It's relatively easy to be sure younger children comply with therapy, because you can watch them take medicine and drive them to their appointments. But as children age, they demand more autonomy. Most teens will not like the idea of being watched every time they take their medicine. They might complain about being too tired or busy to attend a therapy session or may question the need for ther-

apy altogether. For older children these issues will be less of a problem if the doctor deals with them prior to starting any medical or psychological treatment. The first step will be to establish a good rapport, which is essential to ensuring that a teenager understands the treatment and how it is in his or her best interest.

Knowing which therapies are available and how to choose the best one from among the options is essential to getting your child the help he or she needs, but it's not the only requisite. Delivery systems for mental health care of children play an enormous role in the effective treatment of any individual child. These are the gatekeepers to your child's mental health, and the next chapter will help you get what your child needs and deserves.

Chapter 12

Working with the Mental Health Care System

A child who has been diagnosed and is being treated for a psychiatric disorder has two main sources of help: the mental health care system and the school system. Both of these institutions can be tremendous resources, but it takes effort and know-how to get the best they have to offer. You will encounter—and may already have met—many mental health practitioners and educators who are clearly devoted to helping children and who have the insight, intelligence, and expertise to provide what your child needs. Yet, because the organizations they work in are huge bureaucracies governed by complex regulations and laws, they sometimes cannot make your child's welfare their top priority.

This is where you come in. Within each system your child needs an advocate—someone whose first priority is the welfare of your child. You know your child best, and your dedication to your child is unwavering. But to be an effective advocate you must also be well informed. In this chapter I'll tell you how the mental health care and school systems work—the rules of the game—so you can ensure that your child receives the best professional help available from both.

As I've stated throughout this book, your choices in mental health care may be limited by where you live, and unfortunately they probably will also be limited by your insurance plan. That's why it's so important to know how to get the most that your coverage will al-

low—and also where to go when that's not enough. The first part of this chapter addresses these issues.

For children, school makes up a good part of the day and also of each year. What happens at school, both academically and socially, has an enormous impact on the child's present and future welfare. The second part of this chapter tells you how to make sure your child gets not only the best possible education, but also the healthy social development a positive school experience promotes. I'll also tell you how to deal with practical matters such as taking medication during the school day and supporting a teacher's efforts at home. There are, however, dozens of excellent books and other resources that go into much more detail on these subjects than this chapter can.

WORKING WITH THE PRIVATE MENTAL HEALTH CARE SYSTEM

I probably don't have to tell you that the days of choosing your own doctor or hospital and then paying for your care on the way out are long gone, or even that simply being reimbursed by your insurance company is a relic of the past. Today how you get health care, including mental health care, is inextricably intertwined with how it's paid for. What we used to call "medical insurance" is now called a "health care plan," or something like that, because in addition to deciding who pays for what, it also plans what care you get, where you get it, and how you get it.

If you're employed or can afford to pay the premiums on your own, you undoubtedly already have a health care "plan" or "program." The huge variety of such plans fall under the umbrella of the "private mental health care system" because, obviously, these are run by private, for-profit businesses. These corporations' need to make a profit is a critical point, because it has led directly to a veritable revolution in our system of health care. In 1960, the health care costs for one person were only $141 per year. By 1995 that figure had jumped to $3,621, far exceeding the rate of inflation. Eventually, the costs to businesses became so high that they demanded some form of cost control.

These calls for cost control led to the institution of managed care,

which now controls the health care of 85% of working Americans. There are several systems of managed care, but all share a common goal, to manage the cost, quality, and access to health care. Because the differences among managed care systems will have an impact on the quality of care received by your child, you need to understand the implications of each type. Most employers will offer you a choice of plans, which means that new employees must choose wisely and that veteran employees should take advantage of the typical annual opportunity to switch plans if the one they have falls short in providing the mental health care that a child needs. For sure, the choice of a plan could make a major difference in your life if your child has a serious and persistent mental disorder.

HMOs

Health maintenance organizations (HMOs) provide comprehensive health care for a fixed fee that is paid in advance. They operate sort of like huge clinics that offer all the medical services you would ever need. Sounds efficient, but as critics have reported extensively, HMOs have significant disadvantages. First, you have to choose a physician from within the HMO, and that doctor not only provides your care but serves as the gatekeeper who decides whether you should be sent out for medical tests or referrals to specialists. If you don't like the doctors in your HMO or you want a second opinion from outside or you want to see a specialist that your HMO physician doesn't think you need, you'll have to pay for it.

Clearly this approach could have negative consequences for a child with a psychological problem, as for anyone with a medical illness. The goal of an HMO is to control costs, and in some cases cutting costs actually enriches the physicians as well as HMO management. Under the old *indemnity* system doctors referred patients for medical tests solely on the basis of medical necessity for the test. But HMO doctors who are paid through *capitation* receive a lump sum payment for each of their patients, and out of this sum they must pay not only their own salary but also some of the costs of treating their patients, such as the costs of medical tests and referrals to specialist. If they spend too much money on medical tests and specialist referrals, they will make less money.

Supporters of HMOs argue that they provide doctors with the incentive to keep their patients healthy through preventive medicine so that costly tests and other procedures can be avoided whenever possible, without sacrificing the patients' welfare. And in the best possible HMOs, that is what happens. The challenge for parents is to determine not only whether the HMO offered by their employer is one of the best but also what type of mental health services it offers. The latter can be determined by asking your employer's plan administrator the questions in the following section. The former is tougher; see the sidebar on the facing page for tips.

PPOs

The preferred provider organization (PPO) is a network of health care professionals, diagnostic laboratories, and hospitals that forms a complete system of care. "Preferred" means generally that the plan pays more of your costs if you use the practitioners and facilities within the network. If you go outside the preferred list, maybe only 70% of your costs will be covered by your insurance, while staying within the network might mean 90% is covered. The terms vary widely from plan to plan. Physicians get "preferred" status by agreeing on a certain schedule of fees rather than charging whatever they please. They also often have to agree to the insurance company's practice guidelines, which describe which procedures should be used for which medical conditions, or treatment planning procedures that require the insurance company to approve certain tests or treatments ahead of time. If you're using a preferred provider, you won't typically be involved in this planning or approval process, because it takes place between the practitioner and the insurance company. But you should certainly be aware of its existence, because if you should ever wonder why a doctor is not recommending a certain procedure for a certain problem, it could very well be because the cost will have to be absorbed by the practitioner—or you.

Other Plans

America's entrepreneurial spirit has spawned several variants of PPOs and HMOs. For example, the Exclusive Provider Organization

Is Your Employer's HMO a Good One?

- Ask other employees who have opted for this plan what their experience has been: Have they been happy with the doctors they've seen? Did they get the tests that would be standard for their illnesses? (If they're not sure, you'll have to hope that someone is willing to reveal what illnesses family members have been treated for and what tests were done, and then do some research on your own, such as in this book for childhood mental health problems, to determine whether the care seemed up to standards.) How long do they typically wait for an appointment to see their primary-care physician? Is that physician readily accessible by phone? If not, is someone else who seems competent and trustworthy available? How have emergencies been handled? When they've needed a specialist, have they been approved to see one? How long have they had to wait before the appointment? Does the plan limit coverage of prescription drugs in any way? Do they know if the plan has a psychiatrist or psychologist on staff?
- Check with one of the watchdog organizations mentioned in the section on how to choose a plan. If the HMO you're considering gets a low rating, consider another choice. If it hasn't been rated, ask why not.
- Find out how long the HMO has been in business, how many patients it serves, what the patient-to-doctor ratio is, how that ratio has changed with any growth. Has it been either criticized or applauded by watchdog organizations?
- See if you can schedule an appointment just to talk to someone at the HMO about the care provided. This is particularly useful if you already know your child has a mental disorder. You can ask specifically what types of doctors are available, what the rules are for specialist evaluations and what type of prescription drug coverage is available. You should also ask if the benefits for mental disorders are in any way different from the benefits for other disorders.
- Ask for information on the HMO's treatment guidelines. Some plans may provide you with detailed information about what is and is not covered. This information may not always be available, but it's worth asking for it.
- Ask specifically about what mental health diagnosis and treatment specialists and facilities are part of the organization and also about how many children are treated there for mental health problems, which problems, and what treatment has prevailed. Also ask if the mental health team at the HMO has a working relationship with your child's school system.

Is the PPO You're Considering a Good Choice?

- Does the preferred provider network contain a good number of choices within each practice area?
- Are the practitioners on the list ones you would be happy to consult? Look through the list and see if any of the doctors you have used and liked in the past are on it. Ask trusted friends for the names of specialists they have liked and see if they are on the list.
- How much coverage is offered for out-of-network care? The higher the percentage, the better, because you never know when you're going to find that the best doctor for your child is not on the list.
- Most of us know which are the best hospitals in our area. Are these facilities preferred providers or not?
- Does it get a high rating from one of the watchdog organizations mentioned later in this chapter?
- What is the coverage like for prescription drugs? Are they covered? Is there a co-payment? If so, how much?

(EPO) is similar to a PPO in using a network of health care providers but, unlike the PPO, it will not cover any costs for care outside of the EPO network. Like HMOs, EPOs have you choose from their list a primary physician who acts as a gatekeeper for your medical services and whose salary is often tied to his or her ability to control costs. The POS (point of service) plan also has you choose a gatekeeper physician, who must authorize the use of other services. You cannot make an appointment independently with any specialist and have its cost covered. There are some out-of-network benefits, but usually these are lower than with PPO plans.

The ins and outs of each of these will vary widely. The section on how to choose a plan will give you some general questions by which you can compare your options.

Carve-Outs

Many HMO and PPO plans include separate specialty *carve-outs* for health care benefits in specific areas such as dentistry, mental health, and vision care. Some researchers estimate that more than 80% of people are enrolled in such plans. A carve-out is an area of health care that uses different rules from the overall plan. In many cases, the

carved-out services are delivered by an entirely different organization having its own administrative procedures, clinical organization, and internal review policies. Although some claim carve-outs are needed to assure that plan personnel understand the nature of mental disorders and their care, others point out that carve-outs are typically used to reduce the level of coverage for mental as compared with physical disorders. Because carve-outs separate mental health professionals from other personnel, the coordination of services between doctors can be harmed. This can make it difficult, for example, for a pediatrician in the overall plan to coordinate services with a child psychiatrist or psychologist in the mental health carve-out plan. Carve-out plans may also limit prescription drug or psychological therapy benefits.

Because mental health carve-outs are common, you should review your plan carefully to see how the carve-out rules might differ from the master plan. If you expect that your child may need extensive mental health care, the carve-out rules for mental health may greatly affect your ability to provide him or her with appropriate care.

How to Choose a Health Care Plan for Mental Health Benefits

Many of the following questions will not be answered by the brochures and other documentation provided by your company. Most likely, you will need to get complete answers from the administrator of your company's health care plans in the personnel office or, if needed, directly from the health care organization.

- *What types of mental health care are covered?* Be sure to consider both diagnostic and treatment services. Ideally, your plan should allow any diagnostic test that a practitioner would feel is necessary (see Chapter 10). At the very least, it should provide a mental health screening by a nurse, social worker, or pediatrician, who will ask you questions about your child and may have you fill out questionnaires about his or her thinking, emotions, and behavior. But, as Chapter 10 discussed, such a screening may not be enough for a full diagnosis. If your child seems to need more, are there approval or

planning procedures that would cover additional procedures and access to a child psychiatrist and/or child psychologist? As to treatment, consider the types of treatment available, limits on the length of treatment, rules about hospitalization, and reimbursement for medication. As you do this, consult the discussion of treatment methods in Chapter 11, and if you already know or have a good idea of what's wrong with your child, check the roadmap to treatment in the appropriate Part II chapter to be sure your plan covers those that are most effective.

Knowing the types of treatments covered by your plan is only a first step. Most plans restrict the intensity of treatment in some way. For example, if counseling or psychotherapy sessions are covered, they may be restricted to a certain number of sessions. Hospitalizations often are limited to a set number of days. Many health plans will cover the costs of medicines needed to treat your child. The limits on medication coverage can be difficult to decipher.

After you figure out the amount the plan pays for medicine, see if it allows you to use nongeneric medications. As you know from Chapter 11, there are times when a brand-name medication is preferable. There are also cases when no generic is yet available. For example, the new long-acting medications that require children with ADHD to take only one dose each day are not available as inexpensive generics. If your doctor thinks one of these is appropriate for your child (older kids and teenagers, for example, may be embarrassed to have to go to the school nurse for medication in the middle of the day), will your plan pay for it, or will it cover only a short-acting version, which must be taken in the morning and also at school? In general, noncoverage of brand-name drugs means your child will not receive the benefits (unless you pay for them yourself) of the newer medicines, which in almost all cases are developed to improve effectiveness or reduce adverse side effects.

- *Does the plan ration your health care with a gatekeeper?* I mentioned this earlier, but it's worth repeating because by the time most parents decide to seek help for their child's psychological problems, a fair amount of time may already have passed, and you don't want to delay any longer. Yet a gatekeeper, even if you end up allowed to see a specialist, will delay your visit to a specialist or the performance of necessary tests due to time-consuming review procedures.

- *Does the plan use capitation to pay the gatekeeper?* This, too, bears repeating. A capitated gatekeeper has an incentive to deny you access to tests and treatments. If at all possible, avoid plans that use capitation.
- *Is your choice of health care providers limited?* As mentioned earlier, if your HMO or PPO is large enough, there will be a large selection of providers from which to choose. But if the plan is small or does not pay health professionals very well, it may have only a small group of providers—an overall comment on the quality of the plan. Check specifically for the number of mental health care providers. If your plan has only one psychiatrist and one psychologist, you run the risk that they might not be expert enough for your child's problem. You're also very likely to have to wait for a long time for an appointment. If you live in a sparsely populated rural area, you may have no choice due to the scarcity of professionals in the area.
- *Does the plan allow access to nonindicated medicines?* A nonindicated medicine is one that doctors believe will help your child even though the FDA has not approved it for your child's disorder or for use in children. Your doctor will suggest such a drug if he or she knows from the research literature or from clinical experience that it should be effective for your child's condition. Nonindicated treatments are especially important for child mental health because, for most disorders, the research used for FDA approval has used only adult patients. Allowing these treatments provides your child with a wider range of options.
- *Is the plan accredited?* There are many other questions to ask about a managed care organization. But it is nearly impossible for you or any other individual to gain access to information such as whether it is fiscally sound, managed properly, or has reasonable standards for access, reimbursement, and quality control. Fortunately, several organizations have emerged to serve as watchdogs for the public. You should check to be sure that your plan is accredited by one of these organizations. The National Committee for Quality Assurance is an independent non-profit organization that assesses the quality of managed care plans. The Utilization Review Accreditation Commission evaluates and accredits utilization review programs. The Joint Commission on Accreditation of Healthcare Organizations evaluates and accredits hospitals and other health care organizations.

How to Get What Your Child Needs: Appealing an Insurance Decision

Because so many plans include a treatment planning process and prior approval, it's important that you have some way to appeal a decision about what will be covered in your child's mental health care. If you are to be a strong advocate for your child, you will need to mount a vigorous and sustained appeal. You will have several tools to help you with the appeals process. Start with your child's doctor. Find out from him or her as much as you can about the treatment that the health plan has denied your child. Is the usefulness of the treatment documented by research studies? By clinical experience? By both? Is there any evidence that the treatment is more effective than the one chosen by the health plan? Are there any special features of your child's case that favor the use of the disapproved treatment over the standard treatment?

After you've quizzed your doctor, try to document what you've learned as much as possible. If your doctor is willing to be audiotaped, do so and transcribe his or her comments word for word. Ask him to point you in the direction of supportive facts from textbooks or professional journals. Then, to make your appeal, write a letter to the administrator outlining the reasons for your request, enclosing copies of all supporting documentation and indicating that you will make an appointment to speak with him or her in person to discuss the situation. By making these efforts you will send a clear signal to the administrator that you are knowledgeable, prepared, and likely to be persistent in pursuing the best care for your child.

In many cases the administrator will relent and allow your child to have the needed treatment. If not, your next alternative is to send the same letter to the administrator's direct superior. If moving up the company's chain of command fails, your last resort is to seek legal help. But be careful. Because this can be expensive, you should pursue this option only if you have some legal ground to stand on. Most attorneys will provide a free consultation to assess the merits of a case. If your attorney suggests legal action will be worthwhile, be sure to get an estimate of cost as the legal work could be more expensive than the out-of-pocket costs of treatment.

Here's one last thought about the appeals process. When deal-

ing with a big health care bureaucracy it's easy to become frustrated and angry. These emotions are reasonable reactions to a difficult situation, but don't let them get the best of you. You will improve your chances of success if you develop and maintain a friendly relationship with the plan's health care providers and administrators. You will be better off forming an alliance with them against the inequities of "the system" than blaming them for the problems you face. If you anger and alienate them, you reduce their incentive to help you.

WORKING WITH THE PUBLIC MENTAL HEALTH CARE SYSTEM

Unfortunately, about 10 million children lack private health insurance, which leaves them four times more likely than insured children to have an unmet medical need and three times more likely to go without prescription medication. If your family does not have private health insurance, there are public insurance programs for children that may help.

In this section I will describe two public insurance programs that benefit children: Medicaid and the Children's Health Insurance Program (CHIP). Because these programs are run by the states, the rules of access and use will vary somewhat depending on where you live. They also change over time as new laws and administrative rule are enacted. So use the following information as a general guideline, but be sure to contact your state officials for more up-to-date information.

Medicaid and Mental Health

Medicaid is a health care assistance program supported by federal, state, and local taxes. The program serves low-income people of every age. Although patients usually pay nothing for covered medical expenses, in some cases a small copayment is required. Medicaid programs are run by the states, but because they receive federal funds they must operate within federal guidelines.

To find out if you are eligible for Medicaid, contact your local

state welfare office, public health department, or social service agency. Federal law requires states to provide Medicaid to children under age 6 if their family income is at or below 133% of the federal poverty line. States must also provide Medicaid to children age 6–19 if their family income is at or below the federal poverty line. These income guidelines are minimums set by federal law. The law allows states to increase the income level that would qualify a family for Medicaid. Income requirements are sometimes relaxed for special situations (e.g., for very young children or for families with a pregnant mother). You will need to consult your state Medicaid office for details.

The income guidelines are only the first hurdle to receiving services. In some cases, to be eligible, your child must have a specific disability that is approved by the program. The specifics vary from state to state and can change over time, so you will need to check with your local officials to see what is covered. If it is not on that list, the child's problem must be so severe that it prevents normal functioning. In some states, it is possible for children from higher-income families to receive Medicaid coverage if that coverage is needed to prevent them from having to live in an institution. For example, parents of a severely disturbed autistic child may have a health insurance program that does not cover home-based care for their child. If they can show that such care is needed to avoid sending the child to an institution, Medicaid might be willing to provide coverage.

If your child is covered by Medicaid but is not receiving the services he or she needs, you should know about Medicaid's complaint procedures. People insured under Medicaid have the following rights under federal law:

1. They must be informed in writing when a benefit is denied and must be given 10 days' notice before a Medicaid benefit is stopped or reduced.
2. You may challenge a reduction in benefits at a special hearing and are entitled to a written decision within 90 days of a hearing request.
3. If you make a timely request for continued services, your

child should receive continued care pending the outcome of the hearing.
4. If you receive Medicaid benefits through a managed care plan, you can also use the grievance procedures of that plan.

Although Medicaid covers many mental health services, the amount paid to doctors is typically less than they would receive from private health insurance programs. This means that Medicaid patients will have a limited choice of health care providers because some will decide that the fee provided by Medicaid is not sufficient. As a result, many Medicaid patient must use community mental health centers for their care.

The Children's Health Insurance Program

Some families make too much money to qualify for Medicaid, but not enough to afford private insurance. In 1997, to partially fill this insurance gap, the U.S. Congress created the state Children's Health Insurance Program, or CHIP, which is sometimes referred to as Title XXI.

CHIP provides free or low-cost insurance to the children of poor working parents who meet the program's income requirements. But as for Medicaid, eligibility requirements differ among states. For eligible children, CHIP provides regular checkups, immunizations, doctor visits, hospital care, eyeglasses, and prescription drugs. Between CHIP and Medicaid, nearly all children from low-income families are eligible for subsidized health insurance, including coverage for mental disorders, although the details of what is covered vary somewhat among the states.

Although the children of our country are fortunate to have the expanded insurance coverage provided by CHIP, the existence of two health insurance programs can be confusing. For example, in some states, the income guidelines for Medicaid depend on the age of the child. This means that one child in a family may be eligible for Medicaid and another for CHIP. In some states the two programs have different ways of computing your income. Both start with the total amount of money you make each year, but some reduce that by deducting from your income any money you have spent for work-related reasons or for

child care. Some states further adjust income by taking into account the family's assets, such as cars or money in the bank. Learn all you can about these adjustments. They could make the difference between getting health insurance for your family and not.

Although under CHIP most health care costs are paid by the government, each state is allowed to decide if families can be charged for CHIP coverage. But there are some limitations to what your state can charge. For a family at or below 150% of the federal poverty line, CHIP families may be charged $15 to $19 per month for coverage, a copayment for each health care visit (50 cents to $3) and half of the first day of institutional care. States cannot charge children for preventive visits or procedures such as immunizations.

WORKING WITH YOUR CHILD'S SCHOOL

Everyone knows that psychological problems can interfere with a child's learning. But they can create other problems at school too: Your child might be disruptive or even just out of synch with the flow of daily activity, posing a challenge for teachers trying to keep order in the classroom. Your child might have difficulty making or keeping friends, because moodiness or anxiety makes it hard to get along with others, because impulsivity makes it hard to understand the need for mutual respect and to engage in social give-and-take, or just because it's not uncommon for kids to ostracize anyone who is "different"—to name a few of the possible obstacles to social ease. You'll even have to find ways to deal with how your child is to get any medicine that needs to be taken during school—without highlighting his or her "difference" by having your child conspicuously leave the classroom at a certain time every day—and you may need to ask teachers to change their teaching style or characteristics of the classroom to accommodate your child.

Combined, these can be daunting challenges. You'll need to work closely with teachers and school officials to assure that your child receives the help and support he or she needs to do well academically, emotionally, and socially. You'll also have to support the school's efforts at home, whether that means enhancing the benefit of behavior management techniques used at school by using them at home too, monitoring homework diligently, helping teach your child

(e.g., by reading with him or her daily or doing math flashcards) and being sure your child takes medication and participates in therapy as directed. You may have to redefine roles in ways you never imagined, deferring to a competent, caring teacher when you're used to being in charge or even offering to do at home what you might in the past have viewed as the school's job.

If there is one key to breeding success at school, it is this: Be open-minded. Try not to view the school as an obstacle or the teacher as an adversary, even though all your parental instincts may be screaming at you to demand what your child needs and to protect him or her from potential harm. Try anything that the educators at your disposal suggest, at least for long enough to tell if it's going to help. Counterintuitive solutions—like using behavior management at home even when your child seems to misbehave only at school—can eliminate many problems. Listen to suggestions and, if they don't immediately seem right to you, do some research of your own to see whether you can document your point of view—or find evidence that persuades you to change it. Don't let personalities get in the way. The curt response from a harried teacher or the abbreviated discussion with the principal could be products of overwork and underfunding and shouldn't be taken as a sure sign of lack of interest in your child or unwillingness to help. You might find your best ally under the surface of an apparently prickly personality.

Some Principles for Working Effectively with Schools

Asserting your child's rights to special education or other accommodations is a complicated process and will require your determination and diligence. Smoothing out a social path for him or her can take finesse and patience. Ironing out the little practical obstacles often requires trial and error. I'll offer tips for each of these challenges. But the following principles, advocated by the many parents I've known, can promote success in all three areas.

- *Make sure you and all the school staff who will be interacting with your child have a shared understanding of your child's problems.* Whether you're talking to the child's teacher(s), the principal, or a psychologist, counselor, speech therapist, language therapist, reading

teacher, tutor, or other specialist, it doesn't hurt to remind them about your child's diagnosis and the salient issues and problems it creates. Don't assume school personnel are as up-to-date as you about the nature of your child's problem. You may have told the teacher that your child was diagnosed with ADHD, but that doesn't mean he or she has told the reading specialist. Or the teacher may have been the first one to notice your child's problems but hasn't been in touch with you since the diagnosis. If so, he or she may have made some assumptions about what's wrong that are inaccurate now that the child's diagnosis and residual problems have been clarified. Teachers and other educators have a difficult job, especially in crowded public schools. Teacher overload means that some children receive less support and attention than they deserve. As a result, some children fall through the cracks. One of your jobs is to fill in these cracks by updating teachers and other school personnel about the nature of your child's problem.

- *Make sure you know all the "players" in your child's school life.* Your child's teacher will be your primary contact, but there will be times when you will need to be in touch with the principal to iron out administrative matters, and your child may also receive the services of a variety of specialists. You'd be wise to make some kind of initial overture to all of them to introduce yourself, offer to do what you can to make their job easier, and ask what the best way to stay in touch and up to date on their work with your child will be. Even if you don't get much response, maintain periodic contacts, through telephone calls, visits to the school, or e-mail. Even if you have no specific issue to discuss, it is reasonable to ask if there's anything new you should be aware of or anything you can do to help. You will get certain reports mandated by law if your child receives special education services, but periodic personal communications remind everyone that you're interested in a mutually supportive alliance to help your child. You can also use the opportunities to report good news about your child's progress or to thank school staff for their efforts. This helps build a positive relationship and gives teachers the credit they deserve.

- *Establish yourself as the liaison between school and mental health care providers.* Schools and clinicians will have their own systems for sharing information with each other, but you'd be wise not to

assume that all necessary communication is occurring. Teachers spend nearly 6 hours each day in the classroom, which means their observations of your child can help doctors figure out diagnoses and monitor treatment. How your child is improving, remaining the same, or worsening at school can help you and the child's doctor fine-tune treatment so it provides the greatest benefit. Rating scales or checklists like those described in Chapter 10 allow teachers to contribute to a mental health care practitioner's diagnosis without singling out and embarrassing children.

As part of the diagnostic process, some doctors will request school records and will ask teachers to fill out a form such as the Teacher Report Form of the Child Behavior Checklist or the Conners Teachers Rating Scale. Once treatment has begun, there are several different ways that the teacher can report to the doctor her observations of whether your child is improving. The SNAP and ADHD Rating Scales, for example, ask the teacher to rate the frequency of ADHD symptoms. Others simply ask for one overall rating of how well your child is doing. For example, the Clinical Global Improvement scale asks the teacher to rate the child with a number from one to seven, one meaning "very much improved" and seven meaning "very much worse."

There won't necessarily be a rating scale that measures the specific behaviors that are most relevant to your child's psychological problem, however, in which case your doctor may ask the teacher to fill out a Behavioral Report Card, which asks the teacher to rate a group of behaviors chosen by you and your doctor as being the targets that treatment is trying to change. Because the Behavioral Report Card is tailored to your child's problems, it can be more sensitive to the effects of treatment than a standard rating scale.

Be sure you ask the doctor and teacher which methods the teacher is using to track changes in your child's behavior, how often the reports are being reviewed, and whether you can receive a copy of these reports too. Keep in mind, though, that many doctors are willing to share reports only with other doctors qualified to interpret the results of the report.

- *Participate in goal setting.* If you decide to pursue your child's legal rights to an individualized education program or other special education services, discussed later, goal setting will be built into the

process, and you will have the right to participate. But if your child has a psychological problem that does not qualify for legally mandated services, you should be sure that you are involved in setting goals to help your child surmount behavioral obstacles, cognitive limitations, or emotional disturbances. Assuming you are already talking to your child's teacher about his or her problems, start simply by asking how the teacher plans to teach your child and/or manage your child's behavior. If the teacher has no answer at this time, suggest that you schedule a meeting in the immediate future to discuss goal setting. Be sure to ask whether anyone besides you and the teacher should attend.

Attention to setting goals and then monitoring progress toward them should not be limited to discussions with your child's teacher. If your child ends up seeing the school social worker, a therapist, or any other helping professional, be sure to ask what the professional's goals are for your child and then make it your responsibility to check in and ask for updates about progress toward them.

Insisting on goal setting and then consistently referring all discussions back to those goals will keep everyone on track and can serve as a nonjudgmental reminder that you are all working toward the same ends. It can also remind professionals of measures they were planning to take but may have postponed or forgotten, without pushing them to a point where they will react defensively. However, the best way to ensure that you remain allies working toward the same goal is to adopt the following principle as your Golden Rule for Working with Schools . . .

• *Always ask what you can do to help.* Offer to send an e-mail "tickler" about reports that need to be completed or to help the teacher gather needed resources. Whenever you ask about progress toward goals, ask what else you can do to further those goals. Public (and even some private) schools and teachers have very limited resources today, and simply asking what you can do to help will make most teachers and other helpers feel that you empathize with their plight and are there to assist, not create yet another obstacle for them to surmount. Always remember, too, that you can help out at home: Provide a quiet place for your child to do homework, be sure that house rules reinforce the importance of doing homework, and hold

your child accountable for behavior at school that you would not find acceptable at home.

• *Don't take on the burden of teaching and don't expect teachers to take on the burden of parenting.* I said earlier that your definition of parent and teacher roles might have to shift a little, but that doesn't mean wholesale change. If your child's homework assignment is difficult to understand or doesn't seem in keeping with your child's education plan, it's not your job to become a full-time tutor so that your child can keep up. Send a note to the teacher and explain the problem you're observing.

Likewise, it's not the teacher's job to provide what a family should offer. The teacher's job is much easier when the child comes from a home where family members love and respect one another, where there is little conflict between parents, where the child is rewarded and punished in a manner that encourages good behavior and discourages misbehavior, and where the educational goals of the teacher are supported by the parents. If you have problems with family conflict or discipline of children, ask your doctor for advice on how to get help. Behavior management programs, family therapy, and other resources are there for the asking.

Keep in mind that teachers do not always have time to discipline children. And when they do have time, they usually focus their disciplinary efforts on children who disrupt the class because these children threaten not only their own education but also that of their classmates. They may not have time to discipline the child who is quietly staring out the window rather than doing a worksheet or listening to the teacher. Those children will be punished with poor grades, but poor grades will not change the problem behavior. There are many behavior management programs that can be implemented at school, using rewards and other incentives to encourage the child to stay on track with good behavior. But their effect will be magnified if you use the same methods at home, where you have a wealth of possible reward systems to devise based on the child's access to television or computer time, treats, access to toys, extended bedtimes, weekend outings, and other privileges.

• *Get input from your child.* So many people can end up involved in setting goals and solving problems for your child at school

that sometimes the child ends up almost without an active role. To the extent that your child's age, maturity, and psychological strengths allow, the child should always be involved in planning and working toward school success. At the very least, ask your child about his or her school day. Does he or she understand in-class assignments? Is the child getting special services called for by the education plan? Are other students interfering with his or her learning? You'll be surprised about how much you can learn about schools if you just spend some time talking to your child. Also talk to your child about his or her goals, to keep your child focused on what can be achieved, and be sure to celebrate accomplishments. If the goals are well chosen, they will be attainable but will also offer the child a challenge. When you celebrate reaching one, you'll be acknowledging a real triumph.

Is Your Child Eligible for Special Education Services?

Thus far, my discussion of schools has assumed that you have developed a comfortable working relationship with school personnel and that the schools have used all their available resources to help your child. But, sadly, this ideal situation cannot be found in many schools, even those having highly skilled, well-intentioned teachers. Today's public schools suffer in many domains from the intrusion of politics into education: To keep parents happy, politicians require schools to provide comprehensive educational services to children. But to keep taxpayers happy they do not collect enough money for schools to provide the required services. This leaves schools on the horns of a dilemma: They must allocate insuffucient resources (teachers, support staff, educational materials, etc.) to meet the educational needs of all the pupils who need special services. For you and your child the consequence may very well be a school system that is reluctant to identify psychological problems in children and hesitant to tell parents about the special services that are available to kids who do have these problems.

This response might take shape as arbitrarily defining who is eligible for services. Eight-year-old Adam, for example, had a moderate learning disability that interfered with reading. But, because other children in his grade had more severe problems, Adam was not offered the services of a reading specialist, even though he was eligible

for these services. In fact, he was not even tested for a learning disability. His parents obtained his diagnosis by hiring a private psychologist. Some school systems deal with the problem of insufficient resources by spreading the special services very thin—offering limited services to each child. For example, if the number of children with reading problems were to double, they might not hire a second reading specialist. Instead, they might cut each child's time with the specialist in half.

If your child's psychological problems have been brought to your attention by the teacher, he or she will probably give you a hint about what your school system can offer by the advice he or she gives regarding follow up. If the teacher lays out a plan for using the school's resources and tells you exactly how to proceed, you may be lucky enough to be in a school district that has relatively abundant special education resources. If, when you ask what you should do about your child's apparent problems, the teacher seems hesitant or tries to blame poor learning on behavioral problems (e.g., by saying your child simply needs to try harder, to be more attentive, or to stop misbehaving), he or she may be trying to tell you that the school's resources are scarce or lacking in expertise. However you become aware that your child might have a problem, once you know that one exists you need to initiate the process of requesting whatever special education services your child might need.

Initiating the Request for an Evaluation

In a simple letter to the school principal, state (in terms as specific as possible) that you believe your child has a psychological problem that interferes with his or her education and request (1) a comprehensive psychological and educational evaluation of your child and (2) a summary of your child's rights to evaluation and services under all applicable federal and state laws. If your school cooperates, your child will be evaluated and, if found to have a learning disability or psychological problem that has hurt his or her educational performance, the process of determining what special education services your child needs and how to provide them will begin. If the school does not comply with the requests made in your letter, you may need to contact a lawyer; see the sidebar on the next page.

If Your Child's School Does Not Accede to Your Request for an Evaluation . . .

If your school doesn't cooperate with your request and you feel you have nowhere else to turn, contact a lawyer who specializes in special education law:

- If you can afford to pay for a lawyer, ask your school district's legal department for the names of lawyers who have successfully advocated for children in your district. By law, your district must provide you with these names.
- Also ask other parents who have needed legal advice. Usually, a local parent support group will know of such lawyers.
- If you cannot afford a lawyer, see if your community has free Legal Aid services.
- In some cases, schools will have to reimburse you for legal services if your child had been denied legally required services.

Knowing Your Rights under the Law

Even if the school principal complies with your request for a summary of your child's rights under the law, you will be more effective if you learn about these rights independently as well. You can always consult a lawyer for help in understanding these rights. This chapter provides some useful facts but is not meant to offer legal advice or to give you the specific, complete information you need about how your state enforces the protections afforded by federal laws.

Federal and state laws require public schools to provide special services to eligible children. If you have a child with a psychological problem or psychiatric disorder, he or she may be covered by these laws. From the start, however, you should know that these special services, usually referred to under the rubric "special education," vary widely, as illustrated in Table 12.1. In terms of pure educational help, they can range from simple accommodations for very specific learning disabilities, such as allowing your child to make an audiotape of a report if he or she has a writing disability, to assigning your child to a separate class for children who have extensive needs and need intensive, perhaps one-on-one, instruction and assistance.

Eight-year-old Sean impressed teachers and parents with his large vocabulary and fund of knowledge but was consistently earning

TABLE 12.1. Examples of Special Education Services

Hearing tests	School health services
Counseling	Social work services in schools
Medical services	Speech–language pathology services
Occupational therapy	Transportation
Orientation and mobility services	Psychological testing
Parent counseling and training	Behavior management programs
Physical therapy	Tutoring
Classroom accommodations	Access to reading teacher
Recreation	Access to other specialty teachers
Rehabilitation counseling services	Vocational counseling

poor grades on tests even though he did extremely well on most homework assignments. The school psychologist discovered that Sean was inattentive. He failed tests because he spent too much time looking out the window or being distracted by sounds in the hallway. To deal with this, the school allowed Sean to take tests after school in a quiet room with few distractions. This simple accommodation raised Sean's grades from Cs to As in one marking period. Other examples of accommodations are allowing the child use of a calculator on tests, extra time to complete tests, and use of a laptop computer to take notes in class. But some children require more intensive services. Children with reading disabilities need the services of a reading teacher. Children with ADHD may need a tutor to coach them on behavioral skills or help them with specific subject material. Children with severe disorders may need to be placed in a special class with a teacher trained to teach children with psychological problems. In rare cases, the most disturbed of children will need to be placed in special schools designed to manage disturbed behavior and teach children with disabilities.

For many years, children with disabilities were protected under Public Law 94-142. That was amended by Public Law 101-76, which is now known as IDEA, the Individuals with Disabilities Education Act. IDEA requires schools to provide all children with disabilities appropriate education in the least restrictive setting. For eligible chil-

dren, these services must be provided through age 21. Your child may also be covered by the Americans with Disabilities Act, which prohibits discrimination against people with disabilities.

These laws place psychological disabilities on an equal footing with physical disabilities. As you can imagine, these legal protections have had an enormous impact on the education of children with psychological disabilities. By empowering parents with legal rights, the law prevents schools from (1) ignoring psychological disabilities and psychiatric disorders, (2) withholding needed educational services, and (3) placing children with psychological disabilities in "special" classes that are focused on controlling behavior rather than providing an education.

Although different school districts will have their own specific interpretations about who is eligible for legally mandated services, you should know that there are several general ways for a child to qualify. The first is relatively straightforward. Any child who has a learning disability should qualify for services. As was discussed in Chapter 7, to qualify for a learning disability the child must show a substantial discrepancy between overall intelligence and achievement in one or more academic subjects. One source of confusion for parents is that this definition, which is used by the American Psychiatric Association, is not uniformly used by school districts. Thus, you could end up in the peculiar position of having your school disagree with a mental health professional who has diagnosed your child as having a learning disability.

To complicate matters, many children with psychological problems or psychiatric disorders do not have a learning disability but still qualify for services under IDEA. But because this determination is based on some subjective judgments, you must carefully evaluate any decision that denies services to your child. To be eligible for extra educational services under IDEA, medical and psychoeducational evaluations must first show that the child has one or more physical or psychological impairments. The term "psychoeducational" means that the evaluation should determine how a child's psychological strengths and weaknesses affect the ability to learn in school. For the child to qualify for special services under IDEA, the evaluation must also show that the child's impairments or disorders hinder the child's ability to benefit from the standard education provided by pubic schools.

To improve your child's chances of receiving special services, it is essential that you demand a thorough evaluation from the school. A brief evaluation may miss some impairments or their consequences. If so, it would erroneously conclude a child is not eligible for services when a comprehensive evaluation of all psychological functions would have discovered education-relevant impairments covered by IDEA. This leads to a simple bit of advice. If you want to increase the chances of your child receiving IDEA-mandated services, be sure he or she gets a comprehensive evaluation. To arrange for this, explain your concerns to the psychologist doing the evaluation. Tell him or her that you want to be sure that the evaluation covers all of the potential neuropsychological functions that may be affecting your child's school performance.

Getting a Comprehensive Evaluation

You should be an active participant in this evaluation. As described in Chapter 10, a competent evaluator should ask you many questions about your child. Your answers to these questions should allow the evaluator to figure out if your child has any of the psychological problems described in Part II. Unfortunately, some evaluators will not ask all the necessary questions. If they describe their evaluation as a "screen" for psychological problems, beware. Mental health professionals use the term "screen" to describe a brief evaluation that seeks to determine if your child needs a comprehensive evaluation.

There are all sorts of good reasons for a school to use screening evaluations. When used properly, they help schools reduce the cost of an evaluation while still allowing them to detect most children in need of special services. But what makes sense for the school system as a whole may not make sense for your child. Detecting "most" problem children may be comforting to statisticians and administrators, but that success means little to you if your child has problems that go undetected. When that happens, parents can become frustrated as they are to left struggle with a problem they are told has no solution.

If you find yourself in that difficult situation, take heart. Your child need not fall through the cracks of an imperfect system. If your child's evaluators fail to detect problems you know to exist, here's a plan that should solve that problem.

1. ***If they don't ask the right questions, make sure you give them the right answers.*** Your first line of defense comes from the facts you've learned from this book about the nature of psychological problems in children. After reading Part II, you should know if your child has signs of a specific problem. If so, you should discuss these with your child's evaluators.

2. ***Seek an independent evaluation.*** If this first line of defense fails, it could be that there is an implicit rule within the school district to diagnose only the most severe cases, because the district has sufficient resources to provide special services to only those with the greatest need. Enrique's mother thought he had ADHD, but the school's psychologist disagreed. "He doesn't pay attention, acts without thinking, and seems terribly overactive," Enrique's mom said. "How can you say he doesn't have ADHD?" The evaluator responded: "Well, I understand your confusion. After all, you did say that Enrique daydreams, fidgets in his chair, calls out in class, and so forth, but all kids do this to some degree. In my clinical judgment, Enrique's behavior is normal for his age. I know he's not getting good grades, but that has nothing to do with ADHD."

The term "my clinical judgment" should always set off an alarm. Evaluators who resort to citing their clinical judgment are saying that their years of training and experience with such children lead them to interpret a child's behavior as normal. They might be right. But I'd be suspicious, because the school's evaluator's goal is different from the parent's goal. As an agent of the school system, the school evaluator's goal is at least in part to serve the school system's need to allocate limited resources to those children in greatest need of services. The trouble is, if you still believe you're right about your child, you can't argue with the clinical judgment of the evaluator. I suggest you thank the evaluator for his or her help and move on to your next line of defense, an independent evaluation.

In some states, the school is required to pay for the costs of this second evaluation, so be sure to check your local laws. To improve your chances of success, the outside evaluator should have outstanding credentials. If you live near a medical school, I suggest you contact its department of child psychiatry. They should be able to provide an evaluation team that consists of a child psychiatrist (for

making psychiatric diagnoses), a psychologist (for assessing intelligence, personality, behavior, and thinking abilities), and other specialists as needed for your child's specific condition. If you do not live near a medical school, I suggest you find a child psychiatrist or psychologist in your area.

If the outside evaluators disagree with the school's evaluation, you will need to discuss this difference with your school principal. Trying to convince a reluctant principal can be difficult and overwhelming, especially if you attempt to do so by yourself. When you are alone in a room with the principal and other school personnel, it is too easy to feel that they are right and you are wrong. If possible, take someone with you to the meeting, ideally one of your experts, but, barring that, at least a supportive friend or relative. Prior to the meeting you should have the independent evaluator send the school a written report of the evaluation along with a cover letter that states, in clear terms, the main findings of the evaluation. It should indicate if your child has a learning disability or some other condition that impairs his or her ability to learn from the standard education provided by pubic schools.

In some cases, the principal will agree with the outside evaluation. In that case you can begin the process of designing an individualized education program for your child. On the other hand, if your child is denied services, you may need to consider legal action. Although it is best to avoid an adversarial relationship with the school, if your child is denied services, you may have no choice. You will need to find a lawyer experienced in educational law.

What Types of Special Education Services Should Your Child Receive?

If the child qualifies for special services under IDEA, the next step will be to come up with an individualized education program, or IEP. *If your child has been approved for special services but has not been offered an IEP, be sure to request one. The school is required by law to provide one.* If the child's problems are considered too mild for IDEA, then he or she may qualify for a modified curriculum or academic program or accommodations such as extra test time under section 504 of the Rehabilitation Act of 1973 and the Americans with

Disabilities Act of 1990. These simple accommodations will aim to create an appropriate learning or test-taking environment or to give the child tools to overcome specific areas of disability.

The "Least Restrictive Setting" Rule: Determining Where Your Child's Services Will Be Delivered

IDEA mandates schools to provide special education services in the least restrictive setting. This means that there is an underlying "rule" that children should be kept in the "mainstream" of education as often as possible, not shunted off to special classes or schools. If a child's disability can be handled within a regular classroom, he or she should not be sent to a "special class" with other disabled children. That marks a child as unusual, creates stigma, and interferes with the child's social development. As a parent you probably know by now that most children like to "fit in" with the crowd. They don't care to be singled out as being odd or unusual.

To deal with this issue, one of the first issues that you and school personnel should address is where your child's special education should take place. You will have a range of choices. Some disabled children can be taught entirely within the usual classroom setting. They will receive some accommodations and, perhaps, extra help from the teacher. But to the average observer, their education will not seem much different from that of the average child. Other children will need more intensive services. As the intensity of services increases, the more they deviate from the usual and the more "restrictive" or different from normal the child's educational setting becomes.

To give you an idea of how different levels of intensity move the child out from the mainstream of education, consider the following options for children with reading disabilities who need more than simple accommodations or extra attention from teachers. The first step outside the mainstream has the child meet with a reading teacher within the classroom, either alone or in a group with other children with learning disabilities. Ideally, this special group meets when the other children in the class are separated into reading groups as well. Because all children are meeting in groups, the children meeting with the resource teacher are not placed in a separate setting that is remarkably different from those of other children.

If the child needs more intense reading help, he or she may need to meet with the reading teacher outside the classroom several times per week. This makes sense if bringing the reading teacher into the class would disrupt other students or if the teaching materials needed by the reading teacher are too bulky to move from classroom to classroom. In this situation the child's educational setting is mostly normal because he or she is outside the regular classroom for only a few hours each week. If handled appropriately by school personnel, this should not embarrass children or alienate them from friends.

Most school districts have special education classrooms for children whose disabilities are so severe that they cannot be handled within the normal classroom setting. If you are considering a special class placement for your child, be sure to carefully weigh its advantages and disadvantages. On the positive side, special education classes are usually much smaller, allowing the teacher to give children more individualized attention than is possible in the normal classroom. Teachers in these classrooms are specifically trained to teach children with disabilities. Their classrooms are equipped with the educational materials and learning aids that children with disabilities need. These teachers will know how to use the educational tools needed to help your child. Also, teachers in this line of work usually want to teach children with disabilities. They enjoy the challenges of special education and will not view your child as an unusual burden.

What I've just described is the ideal situation. You'll need to evaluate any special class proposed for your child. That means meeting with the teacher and asking questions about class size, about teaching methods, about his or her training, about resources available, and about how your child's specific problem fits into the teacher's plan for the entire class. As you speak with the teacher, try to gauge his or her enthusiasm for teaching special children. And find out about his or her experience with children similar to your own. Does the teacher enjoy working with such children? Has he or she made a difference in their lives? Does he or she have specific ideas for how to help your child? Ask to speak with parents who have children in the class with a similar problem. Have these children fared well in the class? Are the parents pleased with the teacher? Do the parents have an open line of communication with the teacher and other school personnel?

As you evaluate a special education class for your child, try to figure out if the special education classroom is used by the school as a way to remove children with behavior problems from regular classrooms. By "behavior" problems I mean the types of behaviors that describe most children with oppositional defiant and conduct disorders and many with ADHD (see Chapter 4). Some schools prefer to manage disruptive behaviors in a special class setting because doing so makes teaching easier for teachers in regular classes. In fact, some research suggests that disruptive behavior is more likely to lead to special class placement than difficulties with learning.

Although regular classes benefit when disruptive children are removed, managing disruptive behavior should not be the main goal of special education classes. Isolating disruptive children is against the law. Although we cannot expect teachers to deal with all types of psychological problems, the law requires teachers to know the basics of dealing with these problems. Teachers should know how to use teaching strategies to help children overcome psychological handicaps. They must also know how to manage disruptive behavior in the classroom using behavioral management methods, which I described in Chapter 11. If your child requires medication to be given during school, the teacher must know how to monitor the effects of medication and the school must be able to provide the medicine in a manner that does not single out the child for ridicule and stigmatization.

When teachers are trained correctly in behavior management techniques and medication monitoring, most disruptive behaviors can be handled in regular classrooms. Using special classes as a holding tank for hard-to-handle kids is also not fair to children in need of these classes. The children who need intensive teaching may not receive it if their teacher must spend most of his or her time disciplining disruptive children.

This problem with the placement of disruptive children may affect you in one of two ways. If your child is not disruptive, you should be wary of any special class placement that lands him or her in a classroom where discipline, not teaching, is the primary activity. If your child is disruptive, you should be wary of a special class placement unless school personnel can provide you with convincing evidence that the placement is for educational, not disciplinary, purposes. The only way you can figure this out is to ask questions of

teachers, principals, and other parents. You may also find help from mental health professionals who have worked closely with the school system. If your school allows it, observing the classroom for several days can also help you better understand the nature of its students and the methods of teaching.

Suppose disruptive behavior is not a problem. And suppose the special education class proposed for your child is run by an experienced and enthusiastic teacher who has sufficient time to deal with a small number of students using outstanding educational materials. Is that the right option for your child? Probably. To be sure, you need to find out why your child's disability cannot be handled within the mainstream classroom using one of the strategies described earlier. If a special education class seems like the right option, see what can be done to make your child's school experience as normal as possible. Will the class be in the same building as regular classes? Will your child attend lunch, physical education, or other activities with mainstream children? What efforts does the school make to "normalize" the school day for children enrolled in special classes?

Creating an Individualized Education Program

IDEA entitles eligible disabled children to an individualized education program or IEP, which details exactly what the child should be taught, where the teaching will take place, what teaching methods will be used and what kind of special efforts and services will be needed to give him or her the best possible education. The IEP is prepared by a team, which includes the child's teacher, parents, and professionals whose opinions are needed to create an effective educational program. Examples of relevant professionals are psychologists, reading teachers, speech therapists, and social workers.

If you become involved in writing an IEP for your child, be sure it specifies what type of therapy your child will receive. By doing so you will achieve several goals. You will learn about any psychological services available at your school that may benefit your child. Even if your child's mental health care occurs outside the school, by including it in the IEP, you can be sure that the school educational team is completely informed of your child's condition. That will help them better interact with your child's doctors. For example, if your child

needs to take medication in school, school personnel may need to dispense an afternoon dose. If your child is under the care of a psychologist, teachers may be able to provide useful feedback about his or her progress.

To create an IEP that works, the IEP team must meet periodically to look closely at your child's unique needs. Remember that the "I" in IEP stands for individualized. The IEP must be tailor-made to address your child's specific problems. By law, IDEA specifies a minimum amount of information that must be included in each child's IEP. But each state and school system is allowed to add information to the IDEA specification as needed to conform to local laws or to better help the child.

There are six main steps to the IEP process:

- *Step 1: Scheduling the first IEP meeting.* Within 30 days after your child has been deemed eligible for special education services, the school must schedule an IEP meeting. The school should contact all participants and schedule the meeting at a time and place that is convenient for both you and school personnel. Before the meeting the school should tell you the purpose of the meeting and provide you a list of all the participants.
- *Step 2: Writing the IEP at the first IEP meeting.* Usually the first phase of the meeting will be an open discussion of your child's problems. Feel free to ask all the questions you want. Many parents have their child's mental health professional attend the meeting so they have someone who can help them interpret the technical jargon that usually flies around the table. The discussion will be followed by group decisions about what strategies should be used to overcome your child's psychological disability. The IEP will also list specific, measurable goals for your child. For example, it might specify that your child will be reading at grade level by the end of 1 year.

After a plan is agreed on, it is put into writing, and you will be given a copy. You will be asked to sign (accept) the IEP or reject it within 30 days. Usually, the IEP team will work for the best interests of your child. So you will probably be happy with their ideas for the IEP. But if you do not agree with the IEP, you should voice your opinion and try to work out a solution. If that fails, you have the right to ask for mediation by your state's education agency.

- *Step 3: Delivering services.* All school personnel who deal with your child will be given a copy of the IEP along with instructions as to their specific responsibilities. They will then provide the special services required by your child's disability.
- *Step 4: Measuring your child's progress and reporting to you.* Although the IEP will usually specify goals for the school year, the school should inform you about your child's progress throughout the school year. These progress reports should indicate if current progress suggests that your child will meet the IEP goals by the end of the year.
- *Step 5: Reviewing the IEP.* At least once each year, but more frequently if you or the school requests it, the IEP team must meet for a review. You must be invited to attend all IEP review meetings. At these meetings, the IEP team will review your child's progress and suggest changes in the program or its goals or the need for additional evaluations. If you disagree with changes suggested by the school, you can request mediation by your state's education department.
- *Step 6: Reevaluating your child at least once every 3 years.* The goal of this evaluation is to see if your child still has a psychological disability covered by IDEA and, if so, what his or her special educational needs are.

Who Should Be on Your Child's IEP Team?

The law requires the IEP team to include the following members: the child's parents, at least one of the child's teachers, someone who represents the school district, someone capable of interpreting the evaluation results, members of other organizations outside the school that may be providing services to your child, the child (if parents and teachers agree that his or her attendance will be helpful), and any other persons with special knowledge about your child who would be helpful in preparing the IEP. It is acceptable for one person to play more than one role at the IEP. For example, your child's teacher may be competent to interpret evaluation results.

Your Role. Many parents are intimidated by the thought of meeting with a group of teachers, administrators, and other educa-

tional experts. They feel outnumbered and not competent to raise questions or challenge proposals. But you must remember that you are not simply an IEP observer. You are a crucial member of the IEP team. You are your child's strongest advocate. You know about your child's strengths and weaknesses from a point of view that no "expert" can reproduce. Your ideas may lead to new plans for improving your child's education. Parents are especially expert at knowing what does and does not motivate their children. Sharing this information with the team will allow it to better plan ways to interest your child in learning. Only parents can report the child's progress at home. A teacher can report the child's reading level, but only a parent can say if the child reads independently at home and seeks out complex reading material.

Another important area for parents is behavior management. If your child needs a behavior management program for controlling disruptive behavior or for motivating the completion of school tasks, that program will be successful only if you fully participate. You can help teachers find effective rewards and punishments. You can also maintain close communication with teachers so that school behaviors can be rewarded and punished at home. Don't make the mistake of separating school and home discipline programs. It simply will not work.

The Teachers' Roles. One or more teachers will participate in the IEP meeting. If your child is in a regular classroom and receives services from a special education teacher (for example, a reading teacher), both the special education teacher and the regular teacher should be present, even if the regular teacher is not providing special education services. If your child is older and has more than one regular teacher, you will need to decide with the school who among them should attend.

The regular teacher should provide information about the curriculum in the regular classroom, any accommodations to the curriculum that will help your child learn, strategies for behavior management, progress toward annual goals, participation in extracurricular activities, and socialization with other children both with and without disabilities.

If a regular education teacher is not present for part or all of the meeting, you should find out why. It is fine for him or her to be ab-

sent if the discussion will focus on some issue that is not relevant for the regular classroom. For example, if the focus is on planning a speech therapy program, then the regular teacher may not be needed. But if the teacher is absent and you think his or her input is needed, you should request that the meeting be rescheduled for a time when the teacher is available.

For sure, the regular and special education teachers should be present together at the initial meeting and for some part of follow-up meetings. The special education teacher should review the child's progress in any special education programs and describe plans for achieving future goals. He or she should also provide ideas about how the regular classroom experience can be modified to benefit your child. This can be as simple as suggesting that a child with ADHD not sit near a window, which offers many distractions. Or, he or she may suggest technical aids or books that would be especially suited to your child.

It is equally important that the special and regular education teachers agree on the best way to test your child. A good test is one that allows your child to demonstrate what he or she has and has not learned. If the regular testing environment creates problems, it should be changed. For example, many children with ADHD test better in nondistracting environments. Other children may need additional time to complete the test or may need to use a tape recorder to "write" answers to essay questions. You need to be sure your child is tested in a manner that shows his or her true strengths and weaknesses. Otherwise, it will be impossible to plan goals or evaluate progress toward achievement.

The IEP will also specify how the special education teacher works with your child. There are several possibilities. Your child may be enrolled full-time in a special class. A less restrictive approach is for your child to be taught in a regular classroom and make periodic visits to the special class teacher for one-on-one or group tutoring. If your child's problems are not too severe, the special education teacher might just "team teach" with the regular teacher on a periodic basis.

The Psychologist's Role. It will be difficult for you to figure out exactly how much special education your child needs. Remember that the special education teacher is a limited resource. If your dis-

trict has one special education teacher serving five schools, services will not likely occur more than once per week, even if more frequent contacts would be useful. To deal with this issue, you ought to bring a mental health professional to the first few IEP meetings. I'd suggest a psychologist experienced with your child's disorder. He or she should have worked with the school before and, ideally, be on good terms with its staff.

The psychologist will also be able to assess the competence of whomever the school assigns to interpret your child's evaluation. He or she may also bring additional evaluation evidence into the IEP. This is crucial because the amount of services your child receives is driven by the interpretation of the evaluation. For example, the school's evaluator may interpret your child's reading scores as only mildly impaired. From that he or she may conclude that your child needs special reading materials but not access to a reading teacher. Your child's psychologist can help you figure out if this is correct or if your child need more intense services.

The School District Administrator's Role. This person sees the "big picture" of special education services in the district, knowing much about state and district regulations and the availability of resources. Be sure to ask if this person has the authority to commit the resources needed to meet the IEP goals. If not, the IEP team may prepare an elaborate plan that will be shot down by the district ad ministration. Here's an obvious tip: Because the administrator controls the resources, try to develop a friendly relationship with him or her.

The Transition Planner's Role. For teenagers, the IEP team should include a person who will plan the child's transition from school to another setting after graduation. Exactly who the transition planner is depends on the nature of your child's disability. For example, this person may represent a vocational school, a college preparatory organization, or, for children with serious disabilities, a sheltered workshop.

Your Child's Role. Should your child attend the IEP meeting if transition is not an issue? If the IEP will discuss your child's transition after public school, he or she must be invited to attend. For other

students, the answer will depend on the child's age, maturity, and ability to understand what the meeting is about. If your child participates, it assures that you, your child, and the teachers have the same basic set of information about your child's education. It also reduces miscommunication. For example, suppose you are under the impression that your child dislikes the reading group. If you bring this up at the IEP and the teacher responds, for example, "But she told me she loves the group," you will be at an impasse.

What Should Be Discussed during the IEP Meeting

Whether it is the first or a subsequent IEP meeting, it usually begins with your child's evaluation. Intelligence tests, personality tests, classroom achievement tests, statewide tests, teacher observations, parent observations, hearing tests, and others should be used to establish three basic facts about your child: current academic performance, intellectual strengths and weaknesses, and other factors that must be addressed to improve your child's school performance. Knowing your child's current performance level is essential to planning reasonable goals. A fifth-grader who is reading at a first-grade level, for example, should not reasonably be expected to be reading at the fifth-grade level in 1 year. Knowing strengths and weaknesses provides insights into the best way to teach your child. For example, a child with a reading disability who has trouble putting together the individual sounds that comprise words but an outstanding ability to understand visual patterns may benefit from reading methods that focus on the visual appearance of words.

Finally, knowing about your child's personality, peer relationships, home environment, and tendency toward disruptive behavior will also provide insight into what the child needs and how to provide it. Shyness, for example, might make a child less likely to reveal lack of understanding and to seek help with schoolwork, so an IEP for a shy child might require the teacher to check the child's understanding on a daily basis. A child who withdraws from others or lacks the skills to form friendships might need a social skills training program. A child who disrupts the classroom may need a behavior management program at school and at home. All of these factors should be discussed at each IEP meeting.

The IEP discussion will lead to a specific plan for helping your child. This plan will specify what is required of teachers, administrators, parents, and the child. It may also decide the child's placement—where the child will be taught. In some states, however, placement is decided by a group other than the IEP team. If that is true in your state, you have the right, under IDEA, to be a member of that group. In general, the school cannot make educational decisions about your child without your input.

What Information Must Be in Your Child's IEP According to IDEA?

According to IDEA, the IEP must provide several specific categories of information about your child and his or her educational program.

Current Performance. The IEP should describe your child's school performance based on classroom tests, assignments, the initial IDEA evaluation, and the observations of parents, school personnel, and health care providers. The purpose of the description is to show how your child's disability affects his or her educational progress and to provide the foundation for planning your child's educational and behavioral goals for the school year. The IEP team must agree that these goals are attainable but also represent substantial educational progress. The goals should address all of your child's specific problems in the areas of academics, socialization, disruptive behavior, physical health or any other area deemed to interfere with his educational progress. It is crucial that the goals be measurable. Otherwise, you will not know if your child's IEP has been successful.

Special Education Services Provided. The IEP must list the specific services, when they will start, where and how often they will be provided, and when they will end. If your child has a reading disability, for example, he or she will be given access to a reading teacher and to specialized reading materials and teaching strategies. If your child has ADHD, the IEP will likely include an in-class behavior management program aimed at controlling, reducing, or eliminating ADHD symptoms. It may also include special accommodations such as allowing your child to be tested alone without distractions.

Methods of Measuring and Reporting on Progress. Most schools evaluate the progress of all students using districtwide or statewide achievement tests. The IEP should state if your child will participate in these tests and if they will modify the testing procedures for your child.

Degree of Removal from the Mainstream. The IEP must specify the degree to which your child will not participate with children without disabilities. Be sure you are convinced that whatever removal is planned is truly needed.

Transition Following School Years. For older children, the IEP must set out a plan for the eventual transition of your child from public school to whatever activity is deemed appropriate after his or her public school years. In the technical lingo of special education, "transition activities" are activities that prepare students with disabilities for adult life. Examples include setting post-high-school educational goals, career planning, and vocational rehabilitation.

The requirement for "transition planning" starts at age 14: the IEP should indicate what specific courses your child should take to achieve postschool goals. When your child is 16, the IEP should describe "transition services," which are the services to be provided to help your child prepare for leaving school and entering adult life. Examples include training in life skills needed to live independently, vocational training for those who will enter the workforce, and study skills training for those who will go on to college.

The IEP is a written document. A good IEP sets detailed goals that are easily measured. When you read the goals, be sure that you have some way of knowing if they are being achieved. The IEP should use precise language to state what it requires of teachers and other service providers. If you child is to be put into a special class, the student–teacher ratio should be stated. If he or she is to receive individual tutoring by a reading teacher, the exact number of hours should be stated. If he or she will be taught with a group of children, the size of the group should be indicated. If the IEP team decides that the regular teacher needs additional training, those plans should be described. There are two additional advantages of a precise plan.

If you move to a new school district, the plan should be so well written that it can easily be implemented by the new school. Otherwise, you will waste valuable time trying to explain what is needed. Also, if you need to take legal action against the school, your battle will be easier if the IEP is written in precise plans. It will be very difficult for your lawyer to prove that the school failed to carry out the IEP if the IEP is vague.

By law, you are entitled to a copy of the IEP at no cost. The school should give a copy of the IEP not only to IEP team members, but also to anyone who will be involved in carrying out the IEP. To keep it simple, be sure that anyone involved with your child's education has a copy of the IEP and understands his or her role in achieving its goals.

IDEA, along with state and local regulations, indicates what information must be in the IEP, but the law does not tell school districts exactly how to prepare the IEP. Because of this, there is no single IEP form that is used throughout the United States. Whatever form is used, it should be easy to understand and use by both educators and parents. If your school uses a form that is difficult to understand, be sure you take time during the IEP meeting to clarify any items that are unclear.

Tips for Making an IEP Work for Your Child

Review and Revise the IEP. In most cases, the first IEP will be only partially correct. Problems will arise or, with age and development, your child will change. Such issues can be addressed only if the IEP team meets now and again to review and revise the IEP. IDEA requires IEPs to be reviewed at least once a year, but these reviews may be held as frequently as needed. Extra review meetings can be requested by either the parents or the school. These extra meetings are your right. Schedule them as needed.

Facilitate Teamwork. The IEP works best when the team members coordinate their activities. Find out if the professionals working with your child have time to talk to one another about his or her progress. If not, speak to the principal about arranging regular meetings. Or even better, write the communication plan into the IEP. Fa-

cilitate communication by knowing all there is to know about your child's progress and communicating this to the IEP team. For example, if the reading teacher tells you that your child's behavior has worsened, be sure the regular teacher is informed.

Communication should lead to adaptation. If problems arise while implementing the IEP, the team needs to adapt quickly, instead of waiting for the next formal meeting. If you see a problem persisting, try to increase the communication among team members. If that fails, have another IEP meeting scheduled. One way to avoid coordination problems is to have the IEP specify who is responsible for coordinating services and how coordination will be documented.

Encourage Staff Development. Don't assume that your child's regular teacher or even the special education teacher has been trained adequately to handle your child's disability. At some point, before the IEP, you should speak privately with the teachers who will help your child. Ask them about their prior experience with similar children. Also find out about any relevant training they have had. It's OK to ask them if they think additional training might be useful. Most teachers like the idea of further personal development. This is usually not a burden, because most schools will give teachers paid time off and cover expenses for a brief training program. If you think the teachers need to learn more about your child's disability, write a teacher training plan into the IEP.

Keep Accurate Records. These records will help you track progress and may resolve disputes about what was or was not agreed on. It will also help document the school's adherence to the IEP and to the requirements of IDEA. If you get into a legal battle with your school, accurate records may be essential. Keep copies of evaluations, IEPs, and correspondence from IEP members and with the school district. If you have an important conversation about your child's care, write down the key points as soon as possible. I suggest you audiotape all IEP meetings. It is your right under the law.

Read before You Sign. Throughout your child's special education, you will be asked to sign many documents. Before signing, be sure you read them carefully. Be sure you understand them. If you

are not sure you agree with what you are signing, ask the school for clarifications, ask an independent health professional, or consult your lawyer. Remember, signing a faulty plan will make it very difficult for you to challenge that plan at a later date.

Appropriate School Discipline for the Disruptive Child

Although IDEA seeks to keep children in the least restrictive environment, it does allow schools to remove students from the regular classroom when their behavior seriously violates the school's codes of discipline. If school administrators believe your child cannot be handled within the regular classroom, the staff should work with you through the IEP process to come up with an appropriate placement. This placement must do more than control the disruptive behavior. It must meet the educational needs of your child and lead to improvements in learning.

In choosing a placement for your child, it is fair for the school to consider the effects your child's behavior has on the learning of other children and their safety when in school. This process frustrates many parents due to the difficulty in balancing their child's needs with those of other students. If you become involved in this type of decision making, it would be a good idea to seek the advice of a mental health professional who is not affiliated with the school. That person can better help you evaluate if the school's concerns about your child's behavior are reasonable and warrant a change in placement outside the regular classroom.

In most cases, parents and school officials can agree on what placement is appropriate for the disruptive child. But if they cannot agree, the law allows the school to remove disruptive children from their regular classroom for up to 10 school days at any one time. In some cases the child will be suspended from school and sent home. In others they may be placed in a more restrictive setting, such as in-school suspension or placement in a special class. The school can only treat pupils with disabilities in this fashion if it is consistent with school policies also applied to disruptive pupils without disabilities. Because there is no limit to the number of 10-day long removals, disruptive children can be bounced back and forth between the regular classroom and a restricted setting. If this occurs it will interfere with

Your Rights as a Parent of a Disabled Child

IDEA gives parents of disabled children many rights. For convenience, I've listed some of the most important ones here. But remember, if you need legal advice, consult an attorney who has experience with education law.

You have the right to:

1. Have the school conduct a psychological and educational evaluation of your child at no cost to you.
2. Have the school pay for an independent evaluation of your child.
3. Examine your child's school records and evaluation results or have someone else review this information.
4. Have all independent evaluations used in making decisions about your child.
5. Have your child reevaluated every 3 years.
6. Request more frequent evaluations if needed.
7. Free special education for your child.
8. An IEP for your child 30 days from the day his or her eligibility for special education was determined.
9. Attend and express your views at all IEP meetings.
10. Bring a friend, advocate ,or health professional to all IEP meetings.
11. An interpreter if you do not speak English or have difficulty hearing.
12. A written copy of the IEP.
13. Approve the IEP.
14. Place your child in a program which meets his or her needs yet allows the child to be with children without disabilities as much as possible.
15. Place your child in a program as close as possible to your home.
16. Have information about your child's progress.
17. A full and nontechnical explanation of all information in your child's school records or evaluations.
18. Request that errors in school records be fixed. If the school refuses, you have the right to an impartial hearing by your state's education department.
19. Have special education services provided to your child up to the age of 21 (in most states).

your child's education. If your child's behavior reaches that level of difficulty, you may need to consider an alternative placement that can better deal with the disruptive behavior.

If your child's behavior is illegal or extremely disruptive, the school has the right to remove the child from his or her regular classroom for up to 45 days. Examples of such extreme behavior are bringing a weapon to school or to a school function, or possessing, selling, or using illegal drugs at school or a school function. Also, if the school administrators believe that a child with a disability is likely to hurt him- or herself or others, they can request that a hearing officer order the child to be placed in a more restrictive educational setting for up to 45 days. After 45 days, if the school administration believes that the child is still dangerous, they can request that the placement continue for an additional 45 days. These 45-day extensions can continue so long as the hearing officer agrees that the child is dangerous to himself or others.

Remember that these disciplinary rules apply only to behavior that is due to a child's disability. If the school decides that your child's misconduct is not due to the disability, then the rules do not apply. Therefore, if your child faces disciplinary action, be sure to ask if the school views the behavior in question as related to the disability. If you are told that it is unrelated and you disagree, you have the right to request a hearing to settle the matter. Any discipline or change in placement must be delayed until after the hearing is completed. But regardless of the final outcome of the hearing, the school must continue education services to your child during the disciplinary period.

As you can see, if your child has been subjected to repeated disciplinary action, it is crucial that you understand his or her rights under the law. But be careful not to get so wrapped up in administrative and legal battles that you lose sight of your main goal, to assure the best possible education for your child. In most cases, if your child faces repeated disciplinary action by the school, that is a sign that the overall treatment plan is not working. That fact should spur you to further action along two lines.

You should review treatment options with his or her mental health care provider. For example, some parents try to avoid medicines for disruptive children by first trying a treatment using psycho-

logical or behavioral methods. If you've done so, but school behavior problems continue, you may need to consider a change in the treatment approach. That change could mean that the current treatment should be more intensive or that you should try an alternative such as adding a medicine to a psychological therapy.

Your second line of action should be to review your child's IEP. In fact, the U.S. Department of Education has told schools that repeated discipline problems may indicate that services provided to the child should be reviewed or changed. Put simply, if the IEP is not working it needs to be fixed. For disruptive children, the IEP should include a separate plan for dealing with disruptive behavior. The goal of the plan should be to prevent behavior problems and, when they occur, to come up with responses other than suspensions out of the classroom, such as detention or community service after school. Preventive strategies include the use of behavior management methods and identifying times when the child is at higher risk for disruptive behavior. For many children, disruptive behavior is more likely to occur in unstructured settings such as the lunch room, the playground or, for older children, in the hallways during a change of classes. If this is so for your child, you need to find a way to add structure to the setting. At lunch your child may need to be separated from other disruptive children or to be seated near a lunchroom aide. He or she may need to give up recess and work quietly in the library. If changing classes is a problem, see if your child can be escorted by a teacher's aide. Each of these solutions does place an additional burden on your child, so you must weigh the costs and benefits carefully before proceeding.

When Disagreements Arise . . .

At some point in your child's education, you may disagree with the school, either on a part of the IEP or on something that comes up during delivery of special services. The first step in resolving disagreements is to reason with school officials. Make a second attempt at explaining your position. Use outside experts to help make your point. If the school remains reluctant, see if you can work out a temporary agreement. For example, if you want teachers to use a different instructional method, perhaps they will agree to try that method for several months. If so, have that written into the IEP. Also, with further discussion, you may change your position. Sometimes what seemed unreasonable in the middle of a busy and complicated IEP meeting seems sensible when you have time for further discussion.

When you enter discussions aimed at resolving conflicts, be careful not to let the discussion turn into a negotiation. Your child's right to disabilities-appropriate education in the least restrictive setting is not negotiable. The school cannot deny an appropriate education due to lack of resources. If your school denies services to your child due to lack of resources, remain steadfast in asking for the services your child needs. You will eventually get what you want through either persuasion or legal action.

A different conflict scenario arises when you and the school disagree about what services are needed to give your child an "appropriate" education. Your working definition of this term should be an education that maximizes your child's potential. When you disagree with the school about what is and is not appropriate, you definitely need to seek the opinion of an independent professional, preferably a psychologist well versed in psychiatric diagnosis, psychological testing, and special education. That professional will let you know if you are correct and, if you are, what arguments you might try to convince the school that your suggestions should be followed.

When you and your child's psychologist attempt to persuade the school, you should focus on two points: your child's potential and the teaching methods needed to elicit that potential. The evaluation of potential will derive from psychological test results, primarily intelligence and aptitude tests. These tests will give your psychologist the hard facts about what level of achievement can be expected from your child. The psychologist's experience will also be valuable here. For example, if he or she has worked with many other children having the same disability as your child, the psychologist will be able to argue that these children can reach certain levels of achievement.

The psychologist's experience will also help prove that a proposed

teaching method is appropriate. If he or she knows from experience that what you propose works, that will strengthen your case, especially if his or her experience also shows that the school's approach is less effective. The psychologist will likely be familiar with research studies that provide further support for your plan.

If friendly discussions with the school fail to achieve your goal and do not convince you the school is right, request that your state education department mediate your dispute. At mediation sessions, you and school representatives will meet with a mediator, someone knowledgeable about special education who is not involved in the dispute. The mediator will propose a solution to the problem. If you think mediation is needed, you ought to contact a lawyer who specializes in special education law. He will be able to protect your child's rights throughout the mediation process.

If mediation fails, you can file a complaint with your state's education department. IDEA mandates that the state resolve the complaint within 60 days. If that fails to resolve the problem, you will need to turn to your attorney to discuss further legal options.

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Resources

GENERAL INFORMATION

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
Phone: 202-966-7300
Website: www.aacap.org

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
Phone: 847-434-4000
Website: www.aap.org

American Psychological Association Public Affairs Office
750 First Street, NE
Washington, DC 20002-4242
Phone: 800-964-2000 or 202-336-5700
Website: www.helping.apa.org

Brain Connections Online
Website: neuro-www.mgh.harvard.edu/brainconnections.html
Dana Alliance for Brain Initiatives
Website: www.dana.org/brainweb

Federation of Families for Children's Mental Health
1101 King Street
Suite 420
Alexandria, VA 22314

Phone: 703-684-7710
Website: www.ffcmh.org

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Boulevard
Suite 300
Arlington, VA 22201-3042
Phone: 800-950-6264 or 703-524-7600
Website: www.nami.org

National Institute of Child Health and Human Development
Building 31, Room 2A32, MSC 2425
31 Center Drive
Bethesda, MD 20892-2425
Phone: 800-370-2943
Website: www.nichd.nih.gov

National Institute of Mental Health
NIMH Public Inquiries
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MA 20892-9663
Phone: 301-443-4513
Website: www.nimh.nih.gov

National Institute on Drug Abuse
6001 Executive Boulevard
Bethesda, MA 20892-9561
Phone: 800-729-6686 (For information on drug abuse)
Phone: 800-662-4357 (For information on counselors, treatment facilities)
Website: www.nida.nih.gov

National Institutes of Health
Bethesda, MD 20892
Phone: 301-496-4000
Website: www.nih.gov

National Mental Health Association
2001 North Beauregard Street, 12th Floor
Alexandria, VA 22311
Phone: 800-969-6642
Website: www.nmha.org

ANXIETY DISORDERS

Anxiety Disorders Association of America
8730 Georgia Avenue
Suite 600
Silver Spring, MD 20910
Phone: 240-485-1001
Website: www.adaa.org

Obsessive–Compulsive Foundation
337 Notch Hill Road
North Bramford, CT 06471
Phone: 203-315-2190
Website: www.ocfoundation.org

Selective Mutism Foundation
PO Box 13133
Sissonville, WV 25360-0133
Website: www.orgsites.com/fl/selectivemutismfoundation

Tourette Syndrome Association
42-40 Bell Boulevard
Bayside, NY 11361
Phone: 718-224-2999
Website: www.tsa-usa.org

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Attention Deficit Disorder Association
1788 Second Street
Suite 200
Highland Park, IL 60035
Phone: 847-432-ADDA
Website: www.add.org

Children and Adults with Attention Deficit Disorders
8181 Professional Place
Suite 201
Landover, MD 20785
Phone: 800-233-4050
Website: www.chadd.org

AUTISM

Autism Society of America
7910 Woodmont Avenue
Suite 300
Bethesda, MD 20814-3067
Phone: 800-AUTISM
Website: www.autism-society.org

EATING DISORDERS

Anorexia Nervosa and Related Eating Disorders
Website: www.anred.com

American Anorexia/Bulimia Association
165 West 46th Street
Suite 1108
New York, NY 10036
Phone: 212-575-6200
Website: www.aabainc.org

National Association of Anorexia Nervosa and Associated Disorders
Box 7
Highland Park, IL 60035
Phone: 847-831-3438
Website: www.anad.org

National Eating Disorders Association
603 Stewart Street
Suite 803
Seattle, WA 98101
Phone: 800-931-2237 or 206-382-3587
Website: www.nationaleatingdisorders.org

LEARNING DISABILITIES

Learning Disabilities Association of America
4156 Library Road
Pittsburgh, PA 15234-1349
Phone: 412-341-8077
Website: www.ldanatl.org

National Center for Learning Disabilities
381 Park Avenue South
Suite 1401
New York, NY 10016
Phone: 212-545-7510 or 888-575-7373
Website: www.ncld.org

MOOD DISORDERS

Depression and Bipolar Support Alliance
730 North Franklin Street
Suite 501
Chicago, IL 60610-7204
Phone: 800-826-3632 or 312-642-0049
Website: www.ndmda.org

National Alliance for Research on Schizophrenia and Depression
60 Cutter Mill Road
Suite 404
Great Neck, NY 11021
Phone: 800-829-8289 or 516-829-0091
Fax: 516-487-6930
Website: www.narsad.org

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About the Author

Stephen V. Faraone, PhD, studies child psychopathology in the Harvard Medical School Department of Psychiatry at the Massachusetts General Hospital, where he is Clinical Professor of Psychiatry and Director of Pediatric Psychopharmacology Research. Dr. Faraone is Co-Editor of the journal *Neuropsychiatric Genetics* and Associate Editor for Statistics and Methodology of the *Journal of Child and Adolescent Psychopharmacology*. He is also a member of the Panel of Biostatistical and Methodology Consultants for the *Journal of the American Academy of Child and Adolescent Psychiatry*. Dr. Faraone is principal investigator on several National Institutes of Health grants designed to clarify the nature and causes of attention-deficit/hyperactivity disorder and is an investigator for studies of juvenile bipolar disorder, substance abuse, and schizophrenia. An author of over 350 journal articles, editorials, chapters, and books, he was the eighth highest producer of high-impact papers in psychiatry (the top-ranked psychologist) from 1990 to 1999 as determined by the Institute for Scientific Information (*Science,* 2000, Vol. 288, p. 959). In 2003, he was inducted into the Children and Adults with Attention Deficit Disorders (CHADD) Hall of Fame in recognition of outstanding achievement in medicine and education research on attention disorders.