

Features the latest treatments—including medication—for

# IT'S

- attention deficit disorder
- anxiety
- eating disorders
- school phobia
- and more

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# NOBODY'S

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# FAULT



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**New Hope and Help  
for Difficult Children**

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**HAROLD S. KOPLEWICZ, M.D.**

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IT'S  
NOBODY'S  
FAULT

*New Hope and Help for  
Difficult Children and Their Parents*

HAROLD S. KOPLEWICZ, M.D.



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*To Linda,  
a truly perceptive,  
wise, and beautiful woman*

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# Introduction to the Paperback Edition

THE DAY *It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents* was published, I started a book tour that took me across our nation. I was able to meet and speak to thousands of parents of difficult children. I listened to their stories of struggling to find the right help for their children in distress, of the ignorance of teachers and even some health professionals. On almost every television show or radio program in which I participated, the interviewer would share a vignette about his or her own troubled child and that child's success with medication. Unfortunately, the interviewers almost always shared these stories off the air—a clear sign that the stigma of mental disorders in children and adolescents is alive and well in the United States. Millions of children suffer unnecessarily in classrooms, on playgrounds, and at home. Their parents continue to be unfairly blamed for their problems. I heard a recent report of a six-year-old boy who broke into a house, stole a tricycle, and brutally beat an infant. The media immediately blamed his mother's marital status, the family's socioeconomic class, and the neighborhood as the cause of the boy's aberrant behavior. The fact that he was probably suffering from a serious psychiatric illness was totally overlooked.

Even as more scientific data comes in about the safety and efficacy of medication in the treatment of mental disorders, the media remain resistant to reporting its positive effects. While we are becoming more accepting of depressed adults' decision to take antidepressant medication, we largely fail to do so when a depressed adolescent's mental well-being is at stake. I see this media bias—which naturally influences how parents consider the issue—even in the subtle use of language in coverage. Articles are more likely to refer to psychiatric medications as “drugs,” while antibiotics and even cancer chemotherapy are referred to as “medicines.”

The bias is still there, but the good news is that Americans are beginning to pay more attention to this issue. This year, Congress passed a bill giving parity or equality to mental illness. In other words, they are mandating that health insurance cover physical and mental illnesses equally. I applaud this act, because more and more research indicates that the no-fault brain disorders that I discuss in this book are as real as physical illnesses. A gene for Attention Deficit Hyperactivity Disorder has been identified. Research is being done to pinpoint the genes for depression, Tourette's syndrome, and obsessive-compulsive disorder. Our understanding of how the brain works is expanding almost daily. Molecular neurobiology is helping researchers develop new models to understand how chemicals carry messages in the brain and affect our emotions and behavior. Pharmaceutical companies have finally recognized the unmet need of children and teenagers with depression and anxiety disorders. Today research is being conducted and data collected to obtain approval for new medicines that will help these kids and eliminate their needless suffering.

Years ago, I took my oldest son, Joshua, on a business trip with me. He was seven and spent the day in an excellent child care program run by the hotel. I spent the day attending conferences. In the late afternoon, we had the opportunity to walk on the beach together and talk. Josh was very happy about being away from school and spending time with me. He held my hand and said, “Can you imagine if we could do this every day?” Somewhat alarmed, I replied, “You mean stop going to school?” He said, “No, just hanging out and being in Florida.” I said, “You mean retire like Grandma and Grandpa?” He looked at me and said, “Dad, don't you know how to imagine?” I never imagined when I entered child and adolescent psychiatry training that we would identify the genes and develop medicines that can change the way the brain works—and by doing so, save the lives of millions of children. We can be more hopeful than ever that new help will come every year to aid difficult children and their parents.

The publication of my book has given me a wonderful opportunity to work with different patient advocacy groups, members of Congress, and many in the mental health profession. If we can all continue to collaborate with and educate parents and teachers, we'll be able to identify children with no-fault brain disorders sooner and get them the help they need to bring out their full potential.

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There are dozens of stories in this book about people I have encountered during my many years of practicing psychiatry. I talk about many children and adolescents I've treated and parents I have counseled. On occasion I describe young people who have been cared for by my colleagues. The facts as I relate them here are accurate, but some of the details have been changed in an effort to keep the identities of all concerned private and confidential.

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The heart of *It's Nobody's Fault* is, I believe, the stories of the children I've encountered over the years. I would not have been able to do those stories justice without the candid contributions of many of the parents of those kids. I am grateful to the many mothers and fathers who agreed to be interviewed and gave so generously of their time, especially Karen Chapnick, Brooke Garber Neidich, Sherry Laniado, Nancy Morris, and Bernard Rosenblum.

Long before there was any thought of a book I was helped more than I can say by Donald Klein, M.D., and Rachel G. Klein, Ph.D., my mentors and good friends. It was they who set me on this path. I thank them both for their advice and their encouragement, and their inspiration.

Somewhere in the pages of *It's Nobody's Fault* I say that one of the most important things a child can do is choose the right parents. I made the best possible choice with mine. Roma and Joseph Koplewicz are remarkable people, and I thank them for everything.

Finally, on the home front I received indispensable wisdom and moral support from my wife, Linda Sirow. Some of my best insights about children come, directly and indirectly, from my three wonderful sons, Joshua, Adam, and Sam. I could not have done it—any of it—without my family.

[Introduction to the Paperback Edition](#)

[Acknowledgments](#)

[Introduction to the First Edition](#)

## [PART ONE](#)

### [Living with a Child's Brain Disorder](#)

[1. It's Nobody's Fault](#)

[2. Brain Disorders and Personality](#)

[3. The Doctor-Patient-Parent Relationship](#)

[4. The Art of Parenting a Troubled Child](#)

## [PART TWO](#)

### [DNA Roulette and the Role of Medication](#)

[5. The Chemistry of the Brain](#)

[6. The Great Medication Debate](#)

## [PART THREE](#)

### [No-Fault Brain Disorders](#)

[7. Attention Deficit Hyperactivity Disorder](#)

[8. Obsessive Compulsive Disorder](#)

[9. Separation Anxiety Disorder](#)

[10. Social Phobia/Shyness](#)

[11. Generalized Anxiety Disorder](#)

[12. Enuresis/Bedwetting](#)

[13. Tourette Syndrome](#)

[14. Major Depressive Disorder](#)

[15. Bipolar Disorder/Manic Depressive Illness](#)

[16. Schizophrenia](#)

[17. Eating Disorders](#)

[18. Conduct Disorder](#)

[19. Pervasive Developmental Disorder, Autism, and Asperger's Disorder](#)

[Afterword](#)

## [APPENDIX ONE](#)

### [A Definition of Terms](#)

APPENDIX TWO  
Resources and Support Groups

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APPENDIX THREE  
Psychopharmacology at a Glance

# Introduction to the First Edition

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## NEW HOPE, NEW HELP

THE FIRST TIME I knew I wanted to be a doctor I was about four years old, sitting in the office of my pediatrician over on Eastern Parkway in Brooklyn. If I close my eyes, I can still see his face and his friendly Norman Rockwell of with the big brown leather furniture and a bowlful of lollipops on the desk. I wanted to grow up to be just like him.

It wasn't until I was in medical school that I settled on psychiatry. I was working in a psychiatric community clinic headed by a man whose conviction and passion were so strong that he excited everyone around him. He was the person I knew who took a "team" approach to treating mental illness. He talked about how medicine worked for certain disorders and psychotherapy worked for other disorders and how sometimes what was needed was a little bit of both was intriguing.

Then, in 1980, I read a book that changed my life. This book, *Diagnosis and Drug Treatment of Psychiatric Disorders: Adults and Children*, opened my eyes as nothing else had to the importance of diagnosis in the treatment of mental illness. What I read also made it quite clear that the role of medication in that treatment was indispensable. It sealed my fate.

Just about the time I became a child and adolescent psychiatrist, I also became a father for the first time, so I discovered for myself how it feels to be a parent. I understand what it's like to want the best for a child and how frustrating not to be able to make the world perfect for a son or daughter. I also know that the last place on earth a parent wants to be with a child is a doctor's office. I've heard parents describe the feeling they get when they find out that something is wrong with their child—"a sinking feeling in the pit of my stomach," they say—and I know what they mean. Parents have told me that there is a special pain attached to receiving unwelcome news from a child psychiatrist, and I can appreciate those feelings as well. Most parents don't need an excuse to feel anxious or guilty about their children. Hearing that a child has psychological problems automatically pushes many mothers and fathers into guilt overdrive.

Over the years I've read many studies about genetics, but now that I'm the father of three, I've learned something firsthand. My wife and I have three sons, and while the boys are remarkably similar in some ways—they look very much alike, for instance—they couldn't be more different in others. One is left-handed, and the other two lead with their right hands. They have very different social skills, anxiety levels, and abilities when it comes to sports, art, and learning. Their temperaments are not at all alike. The genes of their parents combined to make a baby three times, and each time the results were different. In these pages I call this phenomenon *DNA Roulette*. By the time you have come to the end of this book, I hope you'll have a full understanding of what DNA Roulette means.

There are other terms you'll see often in *It's Nobody's Fault*. One of the most important is *no-fault brain disorder*, by which I mean that the disorders examined here—attention deficit hyperactivity disorder, separation anxiety disorder, depression, social phobia, Tourette syndrome, and all the others—exist not because of what a child's parents do but because of how his brain works, the brain that he was born with. As I'll explain, a child's brain disorder is not his parents' fault. It's nobody's fault.

However, finding the right treatment is a parent's responsibility. Parents don't make their children sick, but it is their job to do everything possible to see that their kids get better. The good news is that there is much that can be done today, just that, much more today than even a decade ago. Most of the advances in the treatment of no-fault brain disorders have come in psychopharmacology, the use of medication to treat the symptoms of a no-fault brain disorder. *Medication* is another word you'll be seeing often in this book. Another is *drugs*, a word that stops a lot of parents cold. Many, perhaps even most, of the mothers and fathers who bring their kids to my office have a problem with the idea that a child might have to take drugs to treat a disorder, for a period of months or even years. They worry about side effects and fear that they'll somehow "lose" their child if he's under the influence of medication. What I hope I make clear in this book is that the role of medication in treating no-fault brain disorders is incredibly important. The side effects of *not* taking drugs to treat a serious problem can often be more harmful than those associated with taking the medicine.

One of my first patients as a psychiatric resident was Ned, a boy I don't think I'll ever forget. He was about nine years old when his mother brought him to see me. He had been having a terrible time in school; his performance was poor and his teacher was complaining about his behavior. He didn't have much of a social life either. None of the other kids in the class wanted to play with him, and their parents didn't like having him around.

After making a diagnosis of attention deficit hyperactivity disorder, I prescribed medication for Ned (a small dose of Ritalin twice a day) and saw him once a month for nearly a year. We talked about what was going on in his life, and his parents were going through a particularly unpleasant divorce—and worked on improving his social skills and self-esteem. After the year was up I saw him only every few months, to monitor his progress. His improvement was remarkable in every way. His grades were terrific, he had lots of friends, and his parents said it was a joy to be with the "new Ned."

A few years after I first saw Ned, he invited me to his elementary school graduation. He was getting a class prize for the best science project, and he wanted me to hear his acceptance speech. Ned said that his mother was having a party at the house afterward, and he wanted me to be there too. I told him that I would really like to be there, but I had a few questions.

"Where do you think I should sit?" I asked him.

"Well, if you sit with my mom or my dad, the other one will be jealous," he answered. "Maybe you could sit with my friends' parents."

"Okay. And how should I introduce myself?" I asked.

This question was clearly harder than the first one.

"We can tell people you're my veterinarian," the boy ventured.

"But you don't have any pets," I said.

"I'll say I used to have a bird with a wing that was broken. But then you fixed it, and it flew away."

I told him that I didn't think that making up a story was a good idea, and he agreed to think about it.

Graduation day came, and I stood at the back of the room and listened to Ned's speech. I wasn't able to go to the family party, so after the ceremony Ned took me over to meet his grandparents. "This is Dr. Koplewicz," he said. "He's my... my friend." True to his word, the youngster had come up with a description of our relationship without making anything up. After meeting the family I stayed for a while, watching as Ned, clutching his award, talked animatedly with his friends and family.

When I think about my role in Ned's life, or in the lives of any of the children I care for, the image I always come back to is roadblocks, impediments on the path that keep these kids from getting where they want and need to go. It's my job to help them climb over those roadblocks or push them out of the way. I say to them, "Look, there's a way of getting from here to there. I'm going to show you how." I give them the tools they need to clear the path. Along the way I try to reassure the parents of these troubled kids and give them hope.

That's what I've tried to do in this book as well. I hope that parents and other readers will come away with new hope for their difficult, troubled children and will be inspired to do everything in their means to get their children the help they need in order to lead happy, fulfilling lives.



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## **PART ONE**

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# **Living with a Child's Brain Disorder**

The four chapters of Part One focus on what a no-fault brain disorder is and how it affects—directly and indirectly—the lives of children, their parents, their teachers, their friends, and the rest of the world. This section also explores the role of the health professional in the treatment of children's brain disorders.

## It's Nobody's Fault

It's a typical day in early October. The school year has started, so I'm seeing quite a few new patients. The first child I talk to is William, age seven, who starts my day off with a real bang. William's motor just won't quit. He doesn't sit or even perch. He walks around my office, touching everything as he goes. At one point he sits behind my desk and spins in my chair. William's nickname at home is "The Magician," because he's always making things disappear. "He can lose his homework walking from the kitchen to the bedroom," his mother tells me.

After William comes Margot, nine years old and as quiet and sad as William is animated. Her parents tell me that Margot has trouble sleeping. For the last two months she's been getting up every night and crawling into bed with Mom and Dad. They give her warm milk, rub her back, and put her back in her own bed, but a short time later there she is again. Sometimes they find her asleep on the floor of their bedroom in the morning. When her parents leave my office so that I can speak to the little girl alone, Margot starts to cry. I tell her that Mom and Dad are waiting right down the hall. She begs me to let them stay just outside the door.

I see a lot of good-looking children in my line of work, but my next patient, 11-year-old Kenny, with his dark skin, dimples, and huge hazel eyes, would stand out in any crowd. Kenny has come to see me because his parents are worried that he might hurt himself. According to his mother and father, Kenny has always been conscientious and hardworking, giving "110 percent" to everything he does. His grades are excellent, he's a better than average athlete, and he has plenty of friends. Until recently he seemed fine. A few months ago, however, he turned cranky and irritable. One night not too long ago he became more upset than his parents had ever seen him; he said that he wished he were dead and locked the door to his room. He's been complaining of headaches almost every day.

"She's driving us crazy," said Delia's mother within seconds of crossing the threshold of my office in the midafternoon. Delia, 10 years old, didn't *look* as if she could drive anyone crazy. She had a winning smile and a delightful personality. But she's been making demands at home that her parents can no longer meet. The ritual that she insists on at bedtime is the worst, her parents say. Every night she says, "I love you, Mom" and "I love you, Dad," and her parents have to say, "I love you too, Delia" right back. The problem is, they have to go through this exchange 20 or 30 times before Delia will let them turn off the light. A few nights ago they decided not to follow the script and sent her to bed with just one "I love you" apiece. Delia got hysterical. "She was obviously in real pain," her father told me.

My last patient of the day was Tobias, age 16, who looked, from a distance, like a typical teenager—baggy clothes, huge athletic shoes, single earring, surly expression. Up close I could see that he was pale and tired, and I soon learned that the bagginess of his clothes wasn't just the latest fashion. Tobias had lost a lot of weight. He just didn't feel like eating. In fact, he didn't feel like doing much of anything. "Everything's just so boring" more or less summed it up for him. He didn't make eye

contact when we spoke. His parents told me that Tobias stays up until all hours of the night and then takes four-hour naps after school. He's also missed a lot of school.

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## DISORDERS OF THE BRAIN

William, Margot, Kenny, Delia, and Tobias, like all the other children described in these pages, have many things in common. All of them have brain disorders; all of them have responded well to treatment, including medication; and all of them have parents who care. Their parents have something in common too. When they first brought their children to see me, virtually all of them thought, or at least suspected, that what was wrong with their children was their fault. Those worried, guilt-ridden parents couldn't be more wrong. What's troubling their children is *nobody's fault*.

According to a report issued recently by the Institute of Medicine, one quarter of the United States population is under the age of 18, and at least 12 percent of those under 18 have a diagnosable brain disorder. That's 7.5 million children and adolescents—boys, girls, rich, poor, black, white—with various psychiatric disorders. That's roughly 15 million parents who feel guilty about it.

One of the reasons parents think that they're to blame for their children's emotional and behavioral problems is that people are always *telling* them that they are. Teachers, relatives, friends, even strangers aren't the least bit reluctant to share their opinions with the parents of troubled kids. The mother of Freddy, a six-year-old boy I was treating for attention deficit hyperactivity disorder, summed it up very well when she said, "My husband and I have gotten a lot unsolicited advice, and just about all of it has been bad. First people said all Freddy needed was discipline, and they blamed his illness on us. If I would just quit my job and stay home with him, he'd be fine. My sister thinks that Freddy has problems because I weaned him at three months. She breast-fed her two girls until they were nine months, and they're fine. My husband works long hours, so my family blames him for saying that Freddy would be okay if my husband would take him to more baseball games. People made us feel like negligent, uncaring parents."

Old ideas die hard. Until 20 years ago there was a general belief that early childhood traumas and inadequate parenting were responsible for childhood psychiatric disorders. Although we know better today, that antiquated way of thinking is still supported by many mental health professionals, perpetuated by the media, accepted as gospel by too many teachers and other school officials, and espoused wholeheartedly by well-meaning relatives. People who wouldn't dream of blaming parents for a child's other diseases—asthma or diabetes or multiple sclerosis, for example—don't hesitate to embrace the notion that a child's behavioral difficulties are caused by working mothers, overpermissive parents, or absent dads.

The fact is, when a child has a brain disorder, it is *not* the parents' fault. It is also not the fault of teachers or camp counselors or the children themselves. A brain disorder is the result of what I call "DNA Roulette." In the same way a child comes into the world with large ears, a tendency to go gray in his twenties, or, like Kenny, beautiful hazel eyes and deep dimples, a child is born with a brain that functions in a particular way because of its chemical composition. (The chemistry of the brain is explained at length in [Chapter 5](#).) *It is brain chemistry that is responsible for brain disorders, not bad parenting.*

At conception a child receives genes from his parents, half from his mother and half from his father. As parents with more than one child know very well, those genes aren't donated in exactly the same configuration every time. A child's precise genetic makeup is largely determined by chance. Genetic messages from both parents come together to create many different combinations. If the

DNA Roulette wheel stops spinning on a “lucky” number, the brain works properly and the child is normal. If not, the brain is dysfunctional. There is no reason for parents to feel guilty about the child’s psychiatric disorder. There’s nothing that any of us can do about our genes. The good news is that there is a lot we can do to treat the problems that genes can cause in our children.

Over the past two decades genetic influences in psychiatric disorders among adults have been fairly carefully studied, but science has only recently begun to focus attention on brain disorders in children and adolescents. Still, the studies that we do have are quite persuasive. Studies comparing the frequency of brain disorders in identical twins (who share the exact same genetic makeup) to the frequency of brain disorders in fraternal twins (who are only as genetically similar as any siblings) show that if one twin had a psychiatric disorder, the other twin was more likely to have it too if he or she was an identical rather than fraternal twin. The conclusion: many childhood psychiatric disorders do have a genetic component. Adoption studies that investigated the genetic influences of psychiatric disorders in children who were raised from a very early age by adoptive parents, and compared the incidence of psychiatric disorders with both their biological and their adoptive parents, came to the same conclusion.

Animal models, especially those conducted with Rhesus monkeys, who have a 94 percent genetic similarity to humans, also support the theory that brain chemistry is genetically transmitted. By studying the neurochemistry of these animals and their reactions to stress and other environmental factors, experts have established in yet another way that nature is a stronger force than nurture. Of course, nurture does play a part in determining how a child will feel and behave. An unfavorable environment, in which a child is abused or unloved, certainly will have a detrimental effect. If the child begins life with a brain that is vulnerable to a disorder, a demoralizing environment is still a factor.

## THE FINE ART OF STORYTELLING

“Right after my daughter Serena was born, I was very sick. I spent most of the first year of her life in bed. I gave the baby as much attention as I could, but I was way too sick to be the kind of mother she wanted to be. Serena was difficult as a baby, and over the years she got much worse. There were a lot of problems with her behavior. When she was four, we took her to a child psychiatrist, who told us that Serena had separation anxiety disorder. He said it was probably caused by my not being available to her when she was an infant. If I hadn’t gotten sick, she probably would have been completely normal. One part of me didn’t believe what the doctor said. It isn’t as if I abandoned her or anything. But I felt tremendous guilt anyway. I cried for a week.”

Serena’s psychiatrist wasn’t the first person to make up a story to explain away a child’s problem, and he won’t be the last. People do it all the time; they see a set of symptoms and create a story around them. What’s the rationale of this disorder? they ask. What has happened in this child’s life to explain this abnormal behavior? Traumatic birth, adoption, illness, parents’ divorce, strong mother, weak mother, an overachieving older sister—all of these and many more have been used to rationalize children’s psychiatric disorders. One mother told me that her 10-year-old son wet his bed every night because he had skipped second grade. The impossible behavior of a nine-year-old with obsessive compulsive disorder was attributed to the fact that the little boy, who was always bossing people around, was simply imitating his father, the CEO of a Fortune 500 company.

Even when these ingeniously fabricated stories make a small amount of sense, science is all but ignored. The psychiatrist who told Serena’s mother that it was her sickness that brought on Serena’s

separation anxiety disorder was forgetting the fact that many children with sick mothers—or mothers, for that matter—do *not* end up with SAD. What's more, there are many children with SAD whose mothers have never spent a single day in a sickbed. People who become convinced that causes B often lose sight of the facts. For example, it is widely believed that bulimia is the result of sexual abuse, but there is little evidence to support this theory. Sexual abuse is a common phenomenon, and bulimia is a common disorder; it stands to reason, therefore, that there will be a substantial number of women with bulimia who have been sexually abused. That still doesn't prove a cause-and-effect relationship. Many women who have been sexually abused don't have bulimia or any other disorder, and many women with bulimia have not been abused.

There are millions of people who endure traumatic experiences—abuse, divorce, the death of a loved one, skipping second grade, and so on—without having to be treated for a psychiatric disorder. Naturally, all children are affected by the events of their lives. If a child is abandoned or beaten, it will most certainly change the way he looks at the world and reacts to it. If his parents get a divorce, it will unquestionably have an effect on him, probably a significant effect. But unless he has the brain chemistry that makes him vulnerable to a psychiatric disorder, the child will not end up with a psychiatric disorder. By the same token, a brain disorder doesn't miraculously disappear if the unpleasant environmental factors are altered.

## NORMAL DEVELOPMENT

Not all children develop at precisely the same rate, of course. Still, the developmental milestones that follow will give parents a rough idea of what to expect.

At *one month* a child will react to voices and be attentive to faces. By *four months* he'll smile at people and respond socially to both familiar and unfamiliar people. At *six months* a child will sleep through the night. At about *age one* he'll walk and say his first word, usually "Mama" or "Dada," and he'll have developed a clear attachment to a caretaker, usually but not necessarily the mother. Also at *one year* kids start "pretend play," having tea parties with imaginary food and pretending, for example, that a toy cup is real.

At *two years old* a child can draw a circle, and he starts to use symbolism: a pencil represents a person, or a block becomes a chair. At the same time kids have "idealized representations"; they don't like broken dolls or toys or anything that has something wrong with it. Kids develop empathy at about this time; if a child hears a baby crying, for example, he'll say that the baby's hungry or hurt. By the time a child is two, he'll be comfortable around strangers with his parents nearby and capable of parallel play: two or more children playing in the same room at the same time but not together. The kids may not speak or otherwise interact as they go about their tasks. Most two-year-olds have a hundred words in their vocabulary and speak in sentences of two words, such as "Big boy," "More food," or "Come here." Girls usually have a more advanced verbal ability than boys, so a two-year-old girl probably will have a much more extensive vocabulary than a hundred words.

At around *age three* most children are toilet-trained, and they have a thousand-word vocabulary. They move on to reciprocal play, building sand castles together or engaging in some other mutually enjoyable activity. With reciprocal play there's a connection between children, even if it is a fight. At *three* kids can sit for 20 minutes of story time or some other activity. By the *age of four* they stop wetting their beds at night and use complex grammatically correct sentences. At *four* a child can separate comfortably from his parents; he'll be able to stay at a birthday party for an hour without his mother in the room. He will also be able to share toys, follow the rules of a game, and function in

group with minimal aggression. A four-year-old might be afraid of the dark or of animals, but the fear is usually transient.

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At five years old children like to hear stories read repeatedly and enjoy rituals throughout the day such as having a snack as soon as they get home from school, playing with certain toys in the bath, and sleeping with the same teddy bear every night. At six kids have a vocabulary of about 10,000 words and they learn to read. They frequently start to collect things—rocks, dolls, basketball cards, and so on—and may become fond of superheroes. At seven they may develop superstitions and rituals: step on a crack, break your mother's back.

From age eight through adolescence, children focus on school performance. Competition and ambition become more important in their lives. Boys and girls begin to develop a value system based largely on the beliefs learned from their family. Their social sphere widens, and friendships begin to take on greater meaning.

The developmental milestones associated with adolescence are less specific in terms of age; there are basically five *developmental tasks* that must be accomplished by a youngster between puberty—approximately age 11 for girls and 12 or 13 for boys—and the end of adolescence, about age 22. There are enormous physical changes that take place during adolescence, especially hormonal fluctuations, and brain chemistry goes through changes as well.

The first task youngsters must accomplish is to *separate* from their parents. Naturally, the separation process doesn't happen all at once; it comes about gradually, in steps, such as flirting with ideas that are different from those of their parents or favoring music and wearing clothes that adults hate. By age 22 a young person should be completely comfortable about being separate from his folks regardless of geography. The second task that faces an adolescent is the *development of a network of friends*. At age 13 or 14 a child begins to find his peer group important. The greatest influences in his life remain Mom and Dad, but he's influenced by his friends and shares intimacy with them. The third task is *sexual orientation*. Sexual fantasies usually start at puberty; by the age of 22 a young person—even one who is not sexually active yet, should know which gender arouses him sexually. Task number four is the *setting of educational and vocational goals*. At age 12 that means finishing a major project or learning the history of Syria. When a youngster is 17 or 18, his goal may be to get into college or find a job. By the time he's 22, he should have a good idea of what he wants to be when he "grows up." The fifth and final developmental task of adolescence is *adjustment to the physical changes* that take place during this period. It's important for a child to adjust not just to the specific changes themselves but also to the fact that his changes are different from those of his friends and are taking place at a different rate.

Being mindful of the milestones of childhood and adolescence will help parents to identify problems their child might have. Parents should be on the lookout as well for specific abnormal behaviors that may indicate that a child has a psychological disorder. Some of them are: repetitive actions, such as tapping, hair-pulling, and hand-washing; unreasonable fears, such as not being able to sleep unless the parents are in the same room; agitation and excessive rigidity; nervousness about meeting people; motor or verbal tics; and extremely aggressive, disruptive behavior. The degree and the intensity of these symptoms are what really matter. Occasional lapses into peculiar behavior are not cause for concern.

Parents who have children with brain disorders tend to end up in hospital emergency rooms more often than the average parent—because of accidents, suicide attempts, and other crises—and they're always saying things like, "Whenever there's trouble in the classroom, my kid is bound to be in the middle of it." Being with these kids is challenging and terribly demanding. "I'm not having much fun

with my child. I love him, but I'm exhausted after being with him. And no one else can stand him" is a statement I hear quite often from my patients' mothers and fathers. Many parents are embarrassed by the child's behavior.

Even though they are nobody's fault, there is a lot of parental guilt and blame attached to these disorders, and much of it comes about when parents are slow to notice a problem. One extremely conscientious mother of a boy with pervasive developmental disorder knew by the time her child was two years old that he needed some help, but she feels bad anyhow. She insists that she could have picked up the symptoms of PDD earlier if she had known what to look for. "Because of my son I got involved in a PDD program, and I saw babies who were four or five months old who were already showing signs of developmental delay. If I had known before what I know now, I would have taken him to the doctor much earlier than two."

Another mother and father whose child I've treated reproach themselves for not being aware of their daughter's depression. "She was so good at masking everything. She fooled us," they told me. And they're right. Some children, unable or unwilling or ashamed to ask for help, are masters at disguising the symptoms of their disorders.

A child should be evaluated by a child and adolescent psychiatrist if any of the items on this checklist describes his behavior for at least two weeks:

- Stomachaches or headaches with no physical cause
- Loss of interest in activities previously enjoyed
- Change in sleep patterns
- Change in eating patterns
- Social withdrawal
- Excessive anxiety or fearfulness upon separation from parents; refusal to sleep away from home or alone in his own bed
- Refusal to go to school
- Decline in school grades in several subjects
- Persistent underachievement at school
- Unacceptable behavior in the classroom
- Aggressive behavior
- Stealing, lying, breaking rules
- Inability to speak to peers or adults other than family
- Repetitive behavior; a child becomes overly upset if these actions are prevented or interrupted
- Avoidance of objects or activities not previously avoided
- Mood swings or a dramatic change in mood
- A preoccupation with death or dying; suicidal wishes or threats
- Change in personality, especially from cooperative to irritable or sullen
- Odd or bizarre behavior or verbalizations
- A tendency to confuse fantasy and reality

This checklist and the brief overview of a child's developmental milestones are not meant to be

alarming to parents, but I do hope that if you see that your child is not developing normally or that he's exhibiting unusual behavior, you will be encouraged to do something about it. (Chapters through 19 thoroughly examine the most common brain disorders in children and adolescents.) For example, if a child of two seems exceptionally uncomfortable with people, you should say, "You know what? My kid is supposed to be over this by now. Maybe I should talk to the pediatrician about it. Perhaps I'll get him to recommend a child psychiatrist." There's nothing to be lost by getting some professional advice. The only thing better than prompt treatment of a disorder is the reassurance that nothing is wrong.

## DISTRESS AND DYSFUNCTION

Schoolteachers have the three Rs: reading, writing, and 'rithmetic. Child and adolescent psychiatrists have the two Ds: distress and dysfunction. In deciding whether or not a child needs treatment for a disorder, we look for one or both of the Ds. If a child's symptoms are not causing him or his parents distress or dysfunction, we watch and wait. Perhaps it's not a disorder but the child's style or a element of his personality. If and when the symptoms of a disorder increase and *do* cause distress or dysfunction, we establish a course of treatment, usually a combination of behavioral therapy and medication.

Child and adolescent psychiatrists are in the business of treating children who are sick, not medicating children who aren't sick so that they can become more popular, perform better at a musical recital, or turn a B + average into an A average. Since most children's brain disorders are treated with medication and since all medications have some side effects, no physician is eager to put a child on medicine unless he really needs it. The first line of attack should be and is psychosocial intervention. Medication isn't called for unless there is a diagnosable disorder.

Any physician must weigh the seriousness of a disease against the effects of the cure. Before he treats a child with medication, a child has to be sick *enough*. If a boy bites his fingernails and the medication to get him to stop doing it causes liver failure, we live with the chewed-up nails. After all, there's no dysfunction involved, and the distress is only on the part of the parents. On the other hand, a girl who's banging her head so hard and so often that she detaches her retinas needs a trial of medication to get her behavior under control, even with the risk of side effects.

Distress is not always obvious to spot in children. Some admit it, but many others deny that they're in pain. Distress may manifest itself in any number of ways, many of them in conflict with the other: agitation, depression, social isolation, boisterousness, silence, sleeplessness, giddiness, sadness, and lots of others. Identifying dysfunction is a little more clear-cut. A child is dysfunctional if he doesn't achieve and maintain developmental milestones; if he can't or won't go to school and pay attention; if he doesn't have friends; or if he does not have a satisfying, loving relationship with his parents.

## TAKING CHARGE

"It's been really hard," said a father of a little boy with attention deficit hyperactivity disorder. "I was looking forward so much to being a dad, and when my son finally came along, I was incredibly happy and excited. I wanted to do millions of things with him—all the great stuff my dad did with me. I couldn't wait to play catch and go camping and that kind of thing. Then I found out I was living with a holy terror who was an absolute pain in the neck to spend time with. I hate to admit it, but I was pretty disappointed."



The father's statement is extremely blunt, true, but he's only expressing what many parents with problem children feel. ~~When a baby is on the way, parents are expectant in more ways than one. They are excited, consumed with hopes and fantasies about what the child will look like and how he will be. Parents want their children to surpass them, to live better, more fulfilling lives than their own. They want them to be accomplished, beautiful, and happy. When parents are busy picking out layettes and narrowing down the list of possible baby names, they aren't anticipating illness. Brain disorders—even no-fault brain disorders—are *not* what they have in mind.~~

Accepting the fact that a child has a brain disorder is never easy for parents, even those who finally realize that they're not at fault. It's even harder to cope with the realization that a child's problem is in his brain. After all, parents think optimistically, if the behavioral problem is caused by something environmental, perhaps the child will outgrow it. I've met some parents who are a little downhearted that it's *not* their fault. "I was hoping that it was our divorce that was making our daughter so crazy," another blunt parent said to me. "At least that way she would get over it in time." After all, if bad parenting is what is causing a child's disease, it stands to reason that good parenting can make it better.

Unfortunately, that's not how it works. Parents don't cause the disorders, and they can't cure them either. However, mothers and fathers can and should take responsibility for seeing that their children get professional help, and the sooner the better. The sooner a child's brain disorder is diagnosed and treated, the sooner he can get on with living a full, happy, satisfying life. And that, in the end, is what every loving parent wants.

## Brain Disorders and Personality

Several years ago I was part of a group of psychiatrists and other clinicians who studied the effects of the psychostimulant Ritalin on preschoolers with attention deficit hyperactivity disorder. One part of the study involved observing the children and their mothers at play before and after the child was given medication. A mother and child were left alone in a playroom full of toys and games for 20 minutes, and their activities were monitored—one of the walls was a two-way mirror—and videotaped.

The time allotted to mother and child was divided into three segments: 10 minutes of free play, 10 minutes of cleanup, and 10 minutes of structured tasks. During free play a youngster was allowed to play with whichever toy he chose, with no limit as to the number of toys or the kind of play. The mother was encouraged to play with him. The cleanup was to be done by the child, with the mother supervising the process if necessary. During the 10 minutes of structured tasks the child would sit at a table with his mother, and she would ask him to complete 40 tasks, or as many as the child could manage in the time allowed. The simple tasks—picking out circles, identifying the red triangle, pointing out everything that's blue, and so forth—tested the child's ability to distinguish colors and shapes. What we were really taking note of, however, was the child's ability to focus, pay attention, and follow instructions. We were also interested in the interaction between mother and child.

I'll never forget the day that Christopher, three years old, came in with his mother to be tested. Little Christopher had one of the most severe cases of ADHD most of us had ever encountered. He nearly tore up my office the first day I met him, climbing on the furniture, scribbling on the table, and tossing books and papers around the room. I ended up having to hold him in my lap (quite firmly, I might add) in order to interview him, and even then our talk lasted only a few minutes. Not surprisingly, Christopher had long since been blacklisted by every babysitter in his neighborhood. My diagnosis was ADHD. Christopher's parents agreed to let him take part in our study, and his mother brought him to the playroom a couple of days after our first appointment.

Christopher was by far the most impulsive, inattentive child who took part in our study. During the 10 minutes of free play the boy played with 61 different toys. (Children with a normal attention span may play with as many as five toys in ten minutes, but many three-year-olds will spend the whole time with only one toy.) In truth, he didn't *play* with any of them; he'd just pick a toy up, throw it down, and move on to another. Christopher's mother tried to get him to settle down, running after him and making a strenuous effort to engage him, but nothing worked. The video camera caught it all: Christopher running from toy to toy, not even pausing to look at a toy; mom following along, calling out, "Christopher! Come here! Look at the truck! Christopher! Here's a beach ball! Don't you want to play catch with Mommy?" The faster Christopher moved, the louder and more agitated the mother became. There was complete chaos in the room.

After the time for free play had elapsed, one of my colleagues went into the playroom and told the

boy and his mother that it was time for cleanup. That's when Christopher really went ballistic. He screamed, ~~threw himself down on the ground, and categorically refused to have anything to do with~~ picking up the 61 toys. Again the mother tried to get her son to follow orders. "Chris, honey, come on. Let's clean up," she said, first in a normal voice and then, as the boy's behavior grew into a full-fledged tantrum, more loudly. The noise on the tape is deafening. After a minute of the tantrum we asked Christopher's mother to handle the cleanup on her own.

The structured tasks were a total washout. Christopher would not even sit at the little table, let alone pick out red triangles and blue circles. His mother put him in the chair, but he kept getting up and running around the room. Mom kept trying—"Christopher! Come on! Let's sit down and play some games!" she cried, over and over again—but nothing worked. The mother became increasingly frustrated; she knew that Christopher was capable of accomplishing the tasks, but nothing she did could persuade him to sit down and do it. When the 10 minutes were up, the little boy had not completed one task. The mother was exhausted.

Almost exactly a month later Christopher and his mom came back to do the test again, but by this time the boy was taking 40 milligrams of Ritalin a day. Again, the whole thing was captured on videotape. During free play Christopher chose a Fisher-Price toolbox, and he and his mother sat on the floor playing with it, and *only* it, for the full 10 minutes. It was so quiet in the playroom that we had to adjust the microphones. "You really like this toy, don't you, Chris?" the mother asked softly. "Yes, I love it," the boy answered. Their conversation was lively and pleasant. Cleanup took only a few seconds; there was just the one toy to put away, and Christopher did it as soon as he was asked. Finally, during the structured-tasks portion of the test the youngster sat at the table with his mother and completed 32 of the 40 assignments. The interaction between the two of them was a pleasure to watch; there was give-and-take and lots of laughter. Voices were never raised.

A few months later I had occasion to show the two videotapes of Christopher and his mother—before and after—to a small group of medical students who were doing a rotation in child psychiatry. We asked the students, who knew nothing at all about the study, what they thought had happened in the month between sessions. All of the students came to the same conclusion: the *mother was taking medication*. "In the first tape she's a mess. She's practically driving the kid crazy, constantly yelling at him and giving him a hard time," one med student said. "She's so much calmer and quieter on the medication."

It's true: on the second tape the mother *is* quieter and calmer, thanks to medication, but she's not the one taking it, of course. The medication that brought on the changes in the mother's attitude and behavior, not to mention the tone and the decibel level of her voice, is her son's Ritalin. The "new" Christopher, the one who pays attention and enjoys laughing and playing and talking to his mother, is so much more pleasant to be with that his mother can't help being pleasanter right back. And the cycle continues from there. The mother's yelling and nagging are converted to praise and approval, and the child flourishes. The more his mother likes him, the more likable he becomes, not just to his mother but to everyone else around him as well. After a time, even the babysitters may have a change of heart.

I've described this study at length not to emphasize the effectiveness of Ritalin in the treatment of ADHD—I do that in [Chapter 7](#)—but to open a discussion of how a child's brain disorder affects the way he and the rest of the world interact. Christopher's ADHD did a lot more than make him impulsive and inattentive. It made him unpleasant and unlikable, even to the people who love him most. It made people avoid him, yell at him, and refuse to baby-sit for him. Furthermore, being constantly criticized and yelled at and infrequently praised probably made Christopher's situation even worse. One of the things we learned in our study is that the mothers of children with ADHD don't praise their children as often as other mothers do, even when the children do something eminent

praiseworthy. The mothers of kids with ADHD are more attuned to their children's negative behavior than to their positive behavior; this is not surprising, since there's usually so much more of the negative than the positive.

Although it may not seem so, Christopher is one of the lucky ones. He was only three years old when his brain disorder was discovered and treated. He'd had a couple of years of negativity out there in the world, but it had been largely contained within the family. He hadn't started school, so he had not had a chance yet to alienate his teachers and annoy his classmates. With the help of the Ritalin and his conscientious parents we hope he never will.

## A PERSONALITY IS BORN

Children are born with certain personality traits, which determine how they will behave in the world, how they will learn, and how they'll interact with others. Even newborn infants have personalities. Intelligence, humor, and all the other elements that make up a personality are largely determined in the womb. But that is by no means the whole story. A child's personality development is affected, sometimes very strongly affected, by the environment in which he grows up. A child who is naturally cheerful and optimistic will not remain upbeat for long if the world is constantly giving him or her downbeat messages. Neglected and abused children find it more than a little difficult to maintain the sunny dispositions they were born with. In the same way, having a brain disorder has crucial and sometimes long-lasting effects on a child's personality development.

When Mario, an eight-year-old boy, came to see me, I asked him what he thought his problem was. "I'm a bad boy," he answered. "What do you mean you're a bad boy?" I asked. "I get into trouble a lot of the time," he explained. "Do you want to get into trouble all the time?" I asked. "I don't know if I want to, but I do. I'm just bad," Mario replied. At the ripe old age of eight, Mario is already convinced that he is a failure. Traveling through life surrounded by people who are forever impatient or enraged is bound to have an impact on a child's personality.

Mario is by no means the only child I've encountered with low self-esteem. I see kids every day who think they're bad or stupid or incompetent, who are convinced that they're a thorn in the side of their teachers and a severe disappointment to their parents. "My dad thinks I'm a real screw-up," 11-year-old Ross told me. "He's right. I *am* always screwing up." It's easy to understand what has brought Ross to this sad conclusion. His short life has consisted of one negative experience after another. He's known little else.

## THE LONG-TERM EFFECTS OF A BRAIN DISORDER

Mario and Ross both had attention deficit hyperactivity disorder, ADHD, the most common and most studied of all children's brain disorders. There's a great deal of evidence to suggest that ADHD affects every aspect of a child's life: school, friendships, and family. School is an unpleasant place for these kids, filled as it is with demands and tasks that seem impossible. Some 25 percent of all children with ADHD drop out of high school (as opposed to 2 percent of those kids without ADHD). Obviously, this makes their prospects for employment less than ideal.

The stigma associated with academic failure can last a long, long time. Riley, the 32-year-old manager of a parking garage, recently told me, with some embarrassment, that he had dropped out of school in the ninth grade. "School was like prison to me," he said. "I couldn't sit still. I couldn't

the work. I couldn't wait to get out of there." Riley went on to tell me that he still doesn't read books and he can't even sit through most movies. "I'm just not very intelligent," he concluded. He's wrong about being unintelligent. Riley reads two newspapers every day, runs a busy garage, and has great people skills. He's clearly smart. However, his early failures in school—a result, I believe, of untreated ADHD—left a mark on his self-esteem that may well be indelible. (See [Chapter 7](#) for more about ADHD.)

All of the other no-fault brain disorders have secondary effects on a child's life as well, especially on school performance and self-esteem. A youngster with *separation anxiety disorder* will be reluctant to leave the comfort and solace of home, where his parents are, so his ability to make friends will be impaired. He'll miss out on many positive experiences, such as parties and sleepover dates. Later on the disorder may limit his college and job choices. ([Chapter 9](#) focuses on SAD.)

Kids with *social phobia*, fearful of being mocked, will avoid social situations and with time will become socially incompetent. Many opportunities, both romantic and professional, will be lost. We live in a verbal world, and people who don't make themselves heard are at a distinct disadvantage; they often are thought to be "stupid" or "hostile" or both. (Social phobia is discussed in [Chapter 10](#).)

The "overachiever" symptoms of *generalized anxiety disorder* may seem beneficial at first but children with GAD, unable to relax or enjoy life, are often tiresome and irritating—not the most popular kids in the class. Not being liked by peers is intensely demoralizing, and it may lead to depression, especially if the disorder continues into adulthood. (GAD is the subject of [Chapter 11](#).)

*Obsessive compulsive disorder* has a tremendous effect on a child's personality because of the secrecy and shame that usually are components of the disease. A child who spends all of his time hiding his irrational obsessions and compulsions from other people—even those people closest to him—shuts himself off from the world. OCD is time-consuming; it limits a child's ability to experience and enjoy other activities. It may also keep him away from his studies. Ashamed and guilty about his behavior, he doesn't let himself be open and honest with other people. Naturally that kind of cover-up behavior makes it difficult for the youngster to establish satisfying relationships. One adolescent girl treated for OCD told me that she feels as if she's faking it all the time. Kids with OCD carry a very heavy burden. (For more about OCD, see [Chapter 8](#).)

In some ways youngsters with *Tourette syndrome* have an even weightier load to bear than children with OCD, because many of them are hiding something even worse: they think they're freaks. The motor and phonic tics associated with TS are hard to disguise, so people with this disorder often become homebodies. They don't want to go out in public for fear of being stared at or mocked for what they themselves regard as "crazy" behavior. Again, love, marriage, and fulfilling employment may elude them because they keep their distance from other people. (TS is described fully in [Chapter 13](#).)

*Enuresis/bedwetting* causes kids to feel ashamed, inadequate, and insecure and usually makes them avoid situations in which their disorder will be discovered, such as camping, pajama parties, and sleepover dates—all social activities that most young people enjoy. The effects may be felt for a long time. A 20-year-old man who's had untreated enuresis his entire life (he kept thinking he would "work through it") says he has never had a satisfying relationship with a woman. He had a girlfriend he was crazy about, but it didn't work out. He would have sex with her, he told me, but, because he didn't want to fall asleep, for fear of wetting the bed, he always got up and went home right afterward. His girlfriend, convinced he was thoughtless and uncaring, broke it off. The young man was convinced he'd never get married. ([Chapter 12](#) focuses on enuresis.)

Having *major depressive disorder* has a formidable effect on how a youngster experiences and

relates to the rest of the world. Teenagers with MDD tend to avoid going to school and being with other people, so they may fall behind academically, miss out on dating, and may not have a chance to develop friendships. Their hopelessness—the “glass is half-empty” approach to life—and their social isolation put them at greater risk for suicide. (MDD is the subject of [Chapter 14](#).)

Kids with *bipolar disorder* have difficulty in every sphere of their lives: school performance is impaired; friendships are difficult to maintain; and their relationship with their parents is disturbed and filled with conflict. All of these problems have a huge impact on self-esteem. As time goes by, they are at serious risk for substance abuse and suicide. (For more about bipolar disorder, see [Chapter 15](#).)

Adolescents with *schizophrenia* experience a deterioration of their personality; they become increasingly unresponsive and unable to initiate and maintain activities and friendships. Delusions and hallucinations play a more important part in their lives than the rest of the real world, and they may lose touch. ([Chapter 16](#) focuses on schizophrenia.)

Like OCD, *eating disorders*—anorexia nervosa and bulimia—involve secrecy and activities that are all-consuming of time and energy. An adolescent girl with an eating disorder is limited in her ability and her inclination to interact with her friends and participate in age-appropriate activities. (Eating disorders are covered in [Chapter 17](#).)

Children with *conduct disorder* have problems developing meaningful relationships—being devious, dishonest, and aggressive doesn't usually make children popular—and a lot of difficulty keeping up with their studies at school. The dropout rate for kids with CD is high, as is the likelihood of substance abuse. Not surprisingly, their employment opportunities are limited, and their chances of ending up on the wrong side of the law are better than even. (Conduct disorder is discussed in [Chapter 8](#).)

Children with *autism* find it difficult or impossible to communicate—many can't speak, and others use language in peculiar ways—to learn, or to relate in any meaningful way to their parents or anyone else. Often avoided or ostracized by their peers for being so unusual, children with this and other *pervasive developmental disorders* suffer tremendous blows to their self-esteem. (PDD, autism, and Asperger's Disorder are covered in [Chapter 19](#).)

## TEACHER'S PEST

Aside from his mother and his father, the most important adult in a child's life is his teacher. Just as it is essential for a youngster's well-being and self-esteem that he be cherished and highly regarded by his parents, it is crucial that he be well thought of by his teacher. When a child has a brain disorder that adversely affects his behavior in the classroom, he may be out of luck; even the most patient and understanding of teachers cannot always give him the positive reinforcement he needs.

Another study I was involved in illustrates just how hard it can be for a teacher to deal with a problem child. This time we were interested in finding out how teachers react to the behavior of the students. Our first challenge was to track down the very best teacher we could find—someone conscientious, caring, patient, creative, and skillful at getting the best out of children. We ended up at a grammar school in the Bronx with Ms. Leonard, a veteran first-grade teacher everyone said was the best in the business. When we asked Ms. Leonard if she would help us out, she agreed to leave her own class for a day and teach another group of first-graders a few miles away in Manhattan. We asked her to conduct the class as she usually did, but with two provisions: she was to ignore any negative behavior on the part of the children and praise all positive behavior.

Unbeknownst to Ms. Leonard, one of the kids in her temporary classroom was six-year-old Vincent who had been diagnosed with ADHD but had not yet started taking medication for the disorder. Also in the classroom that day was a *blind observer*—someone who monitors behavior without knowing why. We asked our blind observer to monitor Ms. Leonard’s reactions to four of the children in class, one of whom was Vincent. Every time any of the four children did or said anything, either positive or negative, the observer was to make a note of the child’s behavior and describe the teacher’s reaction to it in one of three ways: *ignore, criticize, or praise*.

Vincent hit the ground running that morning. Before class had even begun, he pulled the hair of the girl in front of him so hard she started to cry. Then he tripped one of his classmates on his way up to the blackboard. When Ms. Leonard gave instructions, he ignored most of them. Ms. Leonard, who richly deserved her reputation as “super-teacher,” was flawless in her almost impossible mission. All day long she ignored all the bad things that Vincent did—shouting out, getting up from his seat, and so on. The behavior of the rest of the class was fine for the most part, and she praised and thanked each child who did something positive.

At about two o’clock in the afternoon, when the school day was just about over, Ms. Leonard handed out some papers to the first person in each row and asked the children to take one and pass the rest back. For the first time that day, Vincent did as he was asked, but Ms. Leonard did *not* praise him for his positive behavior. The blind observer made a note of the action and the reaction of the teacher. “*Ignore,*” he wrote. Soon thereafter class was dismissed.

After class we reviewed the events of the day with Ms. Leonard and congratulated her for her overall handling of the class and for her patience and restraint in the face of Vincent’s impossible behavior. Then we asked her about her slip at the end of the day.

“At about two o’clock, when you asked the kids to pass the papers back, did you notice that Vincent followed instructions?” the interviewer asked her.

“Yes, I noticed,” said Ms. Leonard.

“Oh, we were thinking you might have missed it,” said the interviewer.

“No, I definitely saw him do it.”

“But you didn’t praise the behavior,” the interviewer said. “Remember? You were supposed to praise the kids whenever they did something positive.”

“Yes, I remember,” Ms. Leonard replied. “But after the terrible way that child had behaved all day long, there was no way I was going to say anything nice to him!”

My colleagues and I could do a hundred more studies and dozens of more tests, but one thing was already crystal clear: brain disorders affect a child’s behavior in many ways, directly and indirectly, and a child’s behavior affects the way he is regarded and treated by the outside world. The longer a child goes without treatment, the more damage will be done to his self-esteem and his prospects for success. If Ms. Leonard, superteacher, can’t say anything nice to poor little Vincent, nobody can.



## The Doctor-Patient-Parent Relationship

As I've said before in these pages, a child's brain disorder is not his or her parents' fault, but making sure that the youngster is cared for, promptly and properly, is their responsibility. One of the most important decisions that parents of children with brain disorders make in fulfilling this responsibility is choosing a child and adolescent psychiatrist.

There are other health care professionals besides child and adolescent psychiatrists who help troubled children, of course; psychologists, social workers, speech therapists, tutors, and others also play vital roles in helping these kids. Still, the first person a child with a suspected brain disorder should be examined by is a psychiatrist. That assertion leaves me open to accusations of bias, I know, but I'll stand firm in my conviction that in dealing with no-fault brain disorders, child and adolescent psychiatrists make the best diagnosticians. If a child has an ear infection or a stomach virus, he belongs in his pediatrician's office. If his problem is behavioral, he should consult a child and adolescent psychiatrist.

Because they are physicians—M.D.s—child and adolescent psychiatrists are able to evaluate all aspects of a child's development and behavior (including neurology, psychology, language, speech, and hearing), to make a diagnosis, and to recommend a course of treatment. If the recommended treatment includes medication, psychiatrists are able to prescribe the medicine and monitor its effects. If behavioral therapy is called for, psychiatrists can either do the job themselves or send a child to someone else more suitable. If other help is necessary, such as tutoring, speech therapy, social skills training, cognitive behavioral therapy, or family therapy, a psychiatrist is in an excellent position to direct the parents and child to the appropriate expert.

### CHOOSING A CHILD AND ADOLESCENT PSYCHIATRIST

Of course, not all child and adolescent psychiatrists are the same, and finding one who is suitable for the child and acceptable to you may take some time and effort. *Consumer Reports* doesn't cover the field of psychiatry, so parents in need of a child and adolescent psychiatrist will have to do the research the old-fashioned way, by asking for recommendations and checking out credentials.

Most pediatricians will be glad to point interested parents toward a good child and adolescent psychiatrist. School psychologists, principals, and guidance counselors may be able to help you, as well, and the same goes for other parents whose children have similar problems. Parents' support groups (listed near the end of this book, in [Appendix 2](#)) are also an excellent resource, as are medical schools and university-affiliated medical centers. The American Academy of Child and Adolescent Psychiatry, a professional organization, fills requests for referrals across the nation all the time; it offers not just names but a physician's credentials as well.



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