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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	Nicole Rabner to Christine Macy, cc Laura Schiller, et al, re NYU Speech (partial) (1 page)	11/25/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
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FOLDER TITLE:
New York University Child Study Center, 12/1/98

2012-1035-S
kc1050

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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[001]

[redacted]

Nicole R. Rabner

11/25/98 04:28:22 PM

Record Type: Record

To: Christine N. Macy/WHO/EOP

cc: Laura E. Schiller/WHO/EOP, Noa A. Meyer/WHO/EOP, Jennifer L. Klein/OPD/EOP
Subject: NYU Speech

Christy, I think you called Jen and me yesterday to discuss the NYU speech. Since we haven't yet connected, I thought I would write a quick e-mail with some of my thoughts.

Since the First Lady has spoken on the issue of early childhood development so many times, my first recommendation is to pull the best speeches on this subject -- I recommend (1) the Brain Awareness Award 3/18/98; (2) the Society for Research in Child Development 4/3/97; and (3) the WH Confernece on Early Childhood Development 4/17/97. In the latter two speeches particularly, the First Lady talks about why studying child development is so important -- how far we've come in understanding how children grow and what they need, about her own rich history with this issue (at the Yale Child Study Center and beyond), and about how important it is to infuse public policy-making with a deep understanding of child development findings. In the Research in Child Development speech in particular, Mrs. Clinton stresses that we have to do a better job of understanding recent discoveries and giving them their appropriate weight in policy making. In this same speech, Mrs. Clinton notes the critical importance of investing in research (this is a particularly fitting to note at NYU given the research victories in the recent budget).

I think the First Lady should say how important it is that a great institution like NYU is embarking on a new child study center -- that it's a sign of the magnitude of the issue and how far we've come. The audience will likely also want to hear about Mrs. Clinton's own experiences in this area (i.e. working with Sally Provence) and how it has helped to shape her commitment to children's issues (for example, learning about how important permanence is to children helped to shape her interest in promoting adoption and shortening stays in foster care for children in our public child welfare system -- leading to her work as an legal advocate for individual children and for reforms in general). Finally, she should talk about the WH Conference on Early Childhood Development in terms of how far we've come and and say that there is a real hunger for this information from parents, advocates, policy-makers, etc., as well as a real need to maintain our commitment to research.

Finally, I believe the NYU folks have sent some ideas for her speech -- she may want to touch briefly on projects which the Center is undertaking or exploring.

I'm reachable at home in NJ over the weekend at P6/(b)(6)

Have a great Thanksgiving.

York University
Child Study Center
First Avenue
New York, New York 10016
Phone: (212) 263-6622
Fax: (212) 263-0990

October 21, 1998

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC

Dear Mrs. Clinton:

I am delighted that you will be the first recipient of the NYU Child Study Center Child Advocacy Award. You will receive the award on December 1, 1998 at the first annual benefit for the NYU Child Study Center chaired by Jon and Joanne Corzine. A detailed description of the award is enclosed in the packet.

The importance of establishing the NYU Child Study Center has never been greater for the children and families of our country. Conservatively, 12% of the population under the age of 18 suffer from a psychiatric illness which translates into more than 8 million children and teenagers needing our help. Unfortunately, the stigma and lack of information and knowledge of mental illness prevents many families and educators from identifying these children and helping them receive help. In addition, the lack of access to mental health services throughout our nation compounds this problem and requires us to develop new service delivery models.

The uniqueness of the NYU Child Study Center is to develop models from research advances and apply them to our clinical services, training and community outreach programs. For example, our Institute for Children at Risk has developed and is empirically testing parenting techniques for parents of preschoolers at high risk for developing antisocial behavior. We have taken this program and translated it into a national service program for parents of disadvantaged children entitled ParentCorps. The Senate Labor, Health and Human Services and Educational and Appropriations Bill encourages the Department of Education's Fund for the Improvement of Education (FIE) to provide $2 million for the ParentCorps project. We need your assistance in working with Secretary Riley to ensure that the language translates into funding.

I am sure you are aware of how devastating the effects of mental illness can be on a child, their family and the community, resulting in extraordinary costs in terms of human suffering as well as financial burden to the country. However, recent scientific advances enable us to address this issue in a more systematic and rigorous manner. For example, over three million children in the United States have attention deficit hyperactivity disorder. These children are ten times more likely to drop out of high school. If identified and treated, their lives can change dramatically.

I look forward to celebrating your lifetime commitment to children everywhere on December 1, 1998. If any member of your staff needs information to help in the preparation of your acceptance speech please have them contact me directly.

Very truly yours,

Harold S. Koplewicz, M.D.
Professor of Clinical Psychiatry and Pediatrics
Director, Child Study Center
Director, Division of Child and Adolescent Psychiatry,
Bellevue Hospital Center
Vice Chairman, Department of Psychiatry

HSK/jb

December 10, 1997

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

It is our great honor to invite you to be the first recipient of the Annual Child Advocacy Award of the Child Study Center at New York University's School of Medicine. This award, recognizing the contributions of one individual to the betterment of the lives of children in the United States, will be presented at our first annual gala in December of 1998.

Launched in March of 1997, the Child Study Center is the first program in the New York area to offer children and adolescents complete psychiatric services that are fully integrated with scientific research and education. In collaboration with public and private school systems and other social organizations, the Center provides innovative preventive resources to families. These outreach programs translate scientific research into everyday skills for parents, educators, pediatricians, and mental-health professionals around the country.

We feel it is only appropriate that you should be the recipient of our first award at our first gala event. Your commitment to children's healthcare, children's literacy and quality education far precedes your role as First Lady. Through your clerkship at the Yale University Child Study Center during your law studies, you witnessed firsthand the importance of diagnosing and treating children with psychiatric disorders.

The Child Study Center's commitment to children's mental health reaches beyond patients at the medical center. The Center offers an enriched environment for scientific research in new treatments and in the risks, predictors, and causes of childhood mental disorders. Through our Parenting Institute, which will be offered over the Internet, the Center will offer instruction and guidance through lectures and workshops to help parents meet the day-to-day challenges of raising children. Through our partnership with New York City schools, we are developing curricula to help teachers improve classroom management skills and identify at-risk students. The Center also offers a fully-accredited graduate training program in child and adolescent psychiatry to train future mental-health professionals to deliver state-of-the-art clinical care.

The Child Study Center at NYU seeks to become a national resource. This event and this award will serve as a statement of an important new commitment to children's health in the 21st century. As the foremost champion of children's causes, your acceptance of this award would be an unequaled pledge of confidence. It would be critical to helping the Child Study Center help thousands

New York University Child Study Center
550 First Avenue, New York, NY 10016 (212) 263-6622 Fax (212) 263-0484

NYU Medical Center
NYU School of Medicine

224-5437

of children with learning, behavior, emotional or other mental health problems recapture their childhood and address their futures with health and confidence.

Thank you for your consideration of our invitation. We hope to hold this event on December 1 or 2 of 1998 and can work with your availability. We look forward to hearing from you.

Yours sincerely,

Jon Corzine
Chairman and Chief Executive Officer
Goldman, Sachs & Company
Child Study Center 1998 Gala Chairman

Harold S. Koplewicz, M.D.
Professor of Clinical Psychiatry
Vice Chairman, Department of Psychiatry
Director, Child Study Center

HSK/ec
Enclosures

New York University
Child Study Center
550 First Avenue New York, NY 10016
Telephone: (212) 263-6622 • Facsimile: (212) 263-0484

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CHILD ADVOCACY AWARD

CHILDREN'S MENTAL HEALTH ENSURES AMERICA'S FUTURE

The New York University Child Study Center Child Advocacy Award recognizes an individual who has demonstrated a lifetime commitment to promoting the mental health of children and families. This individual has worked to bring children's mental health to the forefront of the nation's agenda, giving it equal importance with children's physical health. The recipient has worked to eradicate myths and misconceptions about children's mental illness and to educate America's families about available treatment and resources.

The recipient recognizes that securing and protecting the mental health of children is essential for the well-being of society at large. The recipient works not only to prevent major mental illnesses in children but also to promote factors that enhance the mental health of all children, such as quality education and access to healthcare. The recipient values children's mental health as a key ingredient of our children's educational success, productivity and happiness and has the foresight to invest in children to ensure the future of our society.

New York University
Child Study Center
550 First Avenue New York, NY 10016
Telephone: (212) 263-6622 • Facsimile: (212) 263-0484

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NYU Child Study Center

The NYU Child Study Center is dedicated to the understanding, prevention, and treatment of child and adolescent mental health problems, utilizing the facilities and resources of the world-class NYU School of Medicine. The Center's three-part mission is to integrate comprehensive patient care with state-of-the-art research and training. The Center's scientists are at the forefront of psychiatric research in prevention and comprehensive treatments. The Center offers expert psychiatric services for children and families, with an emphasis on early identification and intervention. Program specialists translate scientific developments and innovative procedures into everyday techniques and strategies for parents, educators, pediatricians and mental health professionals. The NYU Child Study Center aims to set the highest standards in promoting clinical services, research and training in children's mental health.

New York University
Child Study Center
550 First Avenue New York, NY 10016
Telephone: (212) 263-6622 • Facsimile: (212) 263-0484

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NYU CHILD STUDY CENTER PROGRAMS

Clinical Services

Children's Anxiety and Depression Program

Infancy and Early Development Program

ADHD Service of New York

Institute for Learning and Academic Achievement

Outreach and Training

NYU School Partnership

Parenting Institute

ParentCorps

National Public Awareness Campaign for Child and Adolescent Mental Health

Research

Institute for Children at Risk

Institute for Attention Deficit and Other Behavior Disorders

Research Units of Pediatric Psychopharmacology (RUPP)

ParentCorps
A NYU Child Study Center Program

Introduction

It is widely recognized that parents from all socioeconomic groups and cultural backgrounds require help in raising their children. Traditionally, parents have received advice, information and resources through their own parents, extended family, and others in their communities. Dramatic shifts in American society have led to the diminution of many of these essential informal supports. Today, 54% of parents of children aged five and under work outside the home. Thirty percent of all families, and 63% of African American families are headed by single parents (U.S. Census). Societal changes have left parents without the guidance and support of partners, their own parents and other community advisors. Too many parents feel isolated and overwhelmed.

Research from various disciplines shows that parenting is one of the key predictors of problems in youth, including delinquency and antisocial behavior, substance abuse, academic underachievement, and school dropout. Furthermore, in many cases, child abuse and neglect are an unfortunate extension of poor parenting. Numerous controlled studies of a variety of family-focused programs have shown that by improving child rearing practices of young children, childhood behavior problems can be decreased or prevented.

Today's parents, especially those who are economically disadvantaged, have fewer and fewer places to turn for help. Parents need answers and practical advice to everyday questions about: Child Rearing (e.g., "How do I get my daughter to do her homework?"; "How can I get my boys to stop fighting?; "I don't want to hit my child. Is there any other way to get him to do what I want?"; What can I do to keep my son from getting involved with gangs?); Communicating with Schools (e.g., "How do I find out how my child is doing in school?; How do I get more involved in my child's education?; Should my child be reading yet?"; and Finding Information and Resources (e.g., Where can I find an after school program for my teenage son?"; "How can I start a basketball league or girl scout troop in my own neighborhood?").

Recent published reports, reviews and strategic plans on the topic of reaching parents on a wide-spread basis with state-of-the-art, empirically-supported parenting programs suggest that interventions must be broadly focused and delivered within the communities where families live. Parenting programs should be designed not only to help parents adopt parenting strategies that promote their children's social competence and reduce behavior problems, but should also encourage parents to become engaged citizens,

collaborating with teachers, involved in their schools and communities, and helping one another as parents. These are the guiding principles of the ParentCorps program.

Program Goals

The overarching goal of ParentCorps is to develop parent-to-parent networks necessary for the prevention of juvenile delinquency, substance abuse, and academic underachievement. ParentCorps will work with selected organizations in poor communities to identify, train and support a team of highly accessible and visible parent leaders who will be paid to work with parents in their community. Specifically, the cadre of trained parent leaders will help parents in their own communities to: 1) enhance their child rearing skills; 2) improve parent-teacher communication and increase parent involvement within the schools; and 3) access community resources for children and their families. These skills are essential for fostering productive and successful families, schools and communities, and preventing problems in youth.

The strategy to achieve these ambitious goals is to identify parent leaders who will be trained and hired by ParentCorps to conduct parenting skills groups, coordinate workshops on community-identified topics, staff parenting helplines, facilitate referrals to community resources, and provide training on and access to the ParentCorps Website.

We propose a five-year demonstration project to be implemented in underserved neighborhoods in four communities in New York City: the Bronx, East New York/Brooklyn, Lower East Side/ Manhattan, and Harlem. If the pilot project is successful, we plan to expand to other cities, with the ultimate goal of ParentCorps becoming a national service program, supported at the local, state and federal level.

Overview of ParentCorps

ParentCorps will comprise parents with a demonstrated history of community involvement, who will be trained to become Parent R.E.P.s serving as Resources, Educators, and Partners for other parents in the own communities. As Resources, Parent Reps are knowledgeable about all the community resources available to guide parents; as Educators, Parent Reps are well-informed about child development and behavior management principles to help parents influence their children's behavior; and as Partners, Parent Reps work collaboratively with parents, schools and neighborhoods to foster community, school and family involvement and empowerment.

Parent R.E..P.s provide extensive services: Parenting Skill Groups, Parenting Workshops, Parenting Helplines, and information about the ParentCorps Website. Attached is a more detailed description of the R.E.P.'s and their programs and services.

Expert Advisory Board

Prior to program initiation, an external Expert Advisory Board will be created. The Board will meet on a regular basis throughout the five-year demonstration program. The membership of this Board will include prominent individuals from academia, as well as leaders from government, community, and educational organizations. The Board will

serve several purposes: it will provide an outside informal review of the program's progress; offer suggestions regarding programmatic changes and innovations; and facilitate new contacts with other relevant programs and agencies.

Program Standardization and Evaluation

To assist in the dissemination of the ParentCorps program, all aspects of it will be manualized, including training materials, training procedures, collaborative procedures with city, state and federal agencies, and program evaluation procedures. The program will be evaluated in three domains:

- To confirm that the Parent R.E.P's have successfully mastered the training program;
- To evaluate the effectiveness of the ParentsCorps program.
- To evaluate the degree to which the communities take "ownership" of the program.

See attachment for more details of program assessment.

NYU Child Study Center Interdisciplinary Programming

Dr. Laurie S. Miller, Director of the Institute for Children at Risk at The NYU Child Study Center will oversee all aspects of program development, supervision and training, program evaluation and dissemination. ParentCorps will draw on the resources of the faculty of the NYU Child Study Center, who have considerable and diverse parent training experience, having developed and evaluated parent training programs in the context of large-scale clinical trials, prevention studies, services settings, and schools. Additionally, the faculty at the Child Study Center's complementary Parenting Institute provides seminars and parent workshops on a wide variety of relevant issues, ranging from normal development to effective parent-child communication. As such, the NYU Child Study Center, which already serves as an important community resource, is poised to develop, administrate, evaluate and disseminate the ParentCorps program.

Summary

Leaders across a wide range of disciplines agree that educating and supporting parents must be an essential element of any serious effort to prevent childhood behavioral problems as well as for building healthy and strong communities. Unfortunately, information on the specific parenting skills necessary for preventing problem behavior has not been integrated into standard practice and has not reached parents on a wide-spread basis. While there are currently thousands of parenting programs in existence across America, most do not resemble those programs that have demonstrated efficacy, and the majority of community programs are not standardized or closely monitored, thereby limiting their exportability. Finally, most of these programs are not being accessed by poor families whose children are at increased risk of problem behavior.

ParentCorps is based on the premise that training parents of young children, ages 3-8, in child rearing and parent-school communication skills, and facilitating parents' access to community resources, will foster the socioemotional, behavioral and cognitive

development of their children. ParentCorps aims to meet these needs of disadvantaged families by providing a systematic program for developing, monitoring and evaluating parent-to-parent networks that actively engage parents to be more knowledgeable, confident, and effective in their important role of raising the next generation. It is critical that we address these issues now as societal changes have left parents without guidance or support. Parents need, and are looking for, help to ensure their children have happy, healthy and productive futures.

New York University
Child Study Center
550 First Avenue New York, NY 10016
Telephone: (212) 263-6622 • Facsimile: (212) 263-0484

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National Public Awareness Campaign on Child and Adolescent Mental Disorders

Mission

The National Public Awareness Campaign on Child and Adolescent Mental Disorders strives to increase understanding of psychiatric illness and improve access to quality mental health care, offering hope to society in order to protect and nurture the children of tomorrow. Through the Campaign, we will enhance the quality of life for children and parents who continually cope with mental disorders and help to remove the stigmas associated with psychiatric illness.

Overview

Under the leadership of the New York University Child Study Center, the National Public Awareness Campaign on Child and Adolescent Mental Disorders will achieve its mission through a multi-faceted program. This will include the production of a book and national tour of artwork by children living with mental illness, a celebrity narrated videotape, and an educational curriculum designed for middle schools. To most effectively target the Campaign's message and increase our outreach potential during the tour and beyond, the Child Study Center is creating a coalition of advocacy groups including the National Alliance for the Mentally Ill, Children and Adults with Attention Deficit Disorder and Freedom from Fear.

The book, published in collaboration with Harry N. Abrams, Inc. and scheduled for release in the fall of 1999, will incorporate art and statements by children with the most prevalent child and adolescent mental disorders today including, attention deficit disorder and other behavior disorders, learning disabilities, and depression. Along with the images will be brief statements by celebrities who live with these disorders or have children with these disorders. Interviews with noted mental health experts in the eleven categories presented will be included to provide the most current information on etiology, diagnosis, and treatment. By acknowledging the contributing professionals and their institutions and listing mental health facilities across the country, the book will also serve as a national mental health resource.

The Whitney Museum of American Art will hold a special viewing of the art on November 1, 1999. Commencing December 1999 and continuing through 2000, the exhibit will tour to seven cities nationwide. In each city, there will be an opening night event to introduce the exhibit and increase public awareness about the problems facing children and adolescents today. In each city the exhibit visits, a celebrity narrated videotape and educational curriculum will be distributed to all schools in preparation for attending the exhibit and encouraging children to learn about mental illness.

Beyond 2000, the Campaign will continue with the distribution of the videotape and educational curriculum to schools throughout the rest of the country and the development of additional programs for disseminating information to parents, professionals and community organizations.

New York University
Child Study Center
550 First Avenue New York, NY 10016
Telephone: (212) 263-6622 • Facsimile: (212) 263-0484

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Child Study Center
Institute and Program Descriptions

Infancy and Early Childhood Development Program

The Infancy and Early Childhood Development Program is a comprehensive evaluation and treatment program specializing in the unique challenges facing children ages birth through 6 years old. In this field, a relatively under-explored area in child psychiatry, there is growing evidence that very young children, even children with difficulties as problematic as autism, can make use of interventions with more positive change and improvement than can older children. If we can make an early diagnosis of a serious developmental disorder and initiate therapeutic intervention early, we can improve the prognosis of many of these children. The program's interdisciplinary team of Child Study Center experts includes child and adolescent psychiatrists, child psychologists, pediatric neurologists, education and learning disability specialists, speech and language pathologists and occupational therapists. Evaluation and treatment consists of assessing and working with the many domains of a child's functioning from emotions to cognition to language integration to motor skills.

Institute for Attention Deficit-Hyperactivity Disorder (ADHD)

Attention Deficit-Hyperactivity Disorder (ADHD) is a lifelong illness that affects between 5-9% of children and adolescents and 1-3% of adults. The problems associated with ADHD can affect every aspect of an individual's life and functioning. In children, it typically causes difficulties in academic performance and classroom behavior, and often results in problematic social relationships with peers and adults. Adolescents with ADHD frequently endure social isolation, academic failure and family conflict. In adults, ADHD can negatively affect job performance and marriage. Due to frequent failure experiences, individuals with ADHD often experience low self-esteem and other emotional problems. This Institute -- made up of clinical, research, and training components -- investigates new treatments of ADHD, both medication and psychosocial. It focuses on the effect of ADHD throughout life, and other common co-morbid conditions, i.e. learning disabilities, conduct problems, and depression that impact individuals with ADHD.

ADHD Service of New York

This clinical service is for the assessment and treatment of children, adolescents, and adults with ADHD. Assessment consists of structured interviews of psychiatric symptoms and role functioning, historical and behavioral rating scale information supplied by parents and adolescents, and rating scales and telephone interviews completed by teachers. Treatment services include pharmacotherapy and psychosocial treatments, with an emphasis on behavioral approaches, and organizational skills training at home and at school.

We are in a period of significant programmatic expansion, owing to high patient demand for this service. We are developing our clinical information system to facilitate not only administrative functions, but also tracking of response to treatment.

NYU Summer Program for Kids with ADHD

The NYU Summer Program for Kids with ADHD is the first summer program in the New York metropolitan area designed to make summer a fun, productive and successful time for children with ADHD. It is an eight-week, all-day therapeutic clinical program based on research effectiveness. The daily schedule includes a full variety of sports, academic and computer activities, and arts and crafts; social skills strategies are used that are geared specifically to the needs and deficits of children with ADHD. The program has an outstanding counselor to child ratio, with one counselor for every two children. Counselors are graduate students who have received specialized training in behavior modification, social skills training and classroom management. Areas of focus include: classroom behavior, cooperation, academic performance and social skills, as well as athletic skills. Academic remediation is offered for children with specific learning programs. Parents are taught specialized parenting skills to enhance parent-child relations.

Institute for Children at Risk

The Institute for Children at Risk is the first child psychiatry institute to focus on promoting preventive intervention research aimed at reducing well-validated risk factors for mental disorders. By establishing this as a national model, we hope to reach and help whole generations of children at risk for conduct disorder, anxiety disorders, substance abuse, and other mental disorders. Dr. Miller will join the NYU Child Study Center as Director of the Institute for Children at Risk.

The Institute will aim to enhance the effectiveness of preventive interventions both for reducing risk and for increasing scientific understanding of mental disorders. The Institute will conduct prevention trials of interventions that are focused on improving the lives of children by working with families, schools and communities. Experimental trials will address a broad spectrum of questions including short- and long-term program efficacy to reduce mental health problems, development of methods to expand access to programs by high-risk groups, and clarification of factors that determine program effectiveness.

As a starting point, the Institute will focus on prevention trials aimed at reducing the multiple risk factors for children with early onset aggressive behavior. Prevention of aggressive behavior and conduct disorder in youth has strong implications for reducing teenage parenthood, school failure, and school dropout, decreasing criminal behavior and violence in young adulthood, reducing substance abuse and depression and preventing suicide. Consistent with recent recommendations made by the NIMH and the Institute of Medicine reports on the prevention of mental disorders, the long-range goal for the Institute is to develop theoretically-based, rigorously tested, generalizable, and cost-effective preventive interventions for clearly defined mental health outcomes.

The Institute for Children at Risk is generously funded by Joanne and Jon Corzine.

Institute for Learning and Academic Achievement

The Institute for Learning and Academic Achievement offers a comprehensive, professional approach to assessing a child's learning strengths and weaknesses, his current level of cognitive functioning and her academic achievement. The Institute provides an innovative, personalized evaluation strategy, distinct from any other program. The Institute trains child and adolescent psychiatrists, psychologists, and education specialists to identify learning disabled and gifted children and to understand their special school needs. In addition to the clinical and training components, the Institute engages in the ongoing research of intellectual functioning, language development, motor skills, attention, behavior, visual perception, auditory processing and memory. An Institute director is currently being recruited.

The clinical component of the Institute for Learning and Academic Achievement is generously funded by Linda and Richard Schaps.

NYU School Partnership

The NYU School Partnership is an ongoing collaboration between private, public, and parochial schools and the NYU Child Study Center. The Partnership is New York's first citywide, school-based mental health program sponsored by a major academic medical center. Specially trained child and adolescent psychiatrists and child psychologists are available on-site to educate teachers, school psychologists, social workers, and nurses to recognize high-risk students and how to manage this population in a main-stream educational setting. The NYU School Partnership develops collaborations to deliver mental health services in the school setting.

Education Advisory Council

Members of the Education Advisory Council include the chancellor of the New York City public schools, the Associate Superintendent of the Archdiocese of New York, and other leading educators from around the city and the nation. The Council members collaborate to help develop Child Study Center school-friendly programs.

Port Washington Alternative High School Program

This program is geared to adolescents who are academically capable, but have had difficulty in school because of truancy, class cutting or apathy. The program offers a full mental health team -- a psychologist, social worker, and child and adolescent psychiatrist -- on the school's premises. The program enables previously underachieving adolescents to graduate and further pursue their educational interests in college.

School-Based Mental Health Program

The Child Study Center, in collaboration with the Board of Education, other city and state governmental agencies, and school districts notably District Two in Manhattan, is developing school-based psychiatric services. On March 25th, the NYU Child Study Center hosted a day-long conference on enhancing school-based mental health care. National experts met with local policymakers from New York City's Board of Education and Department of Public Health, and New York State's Office of Mental Health and Departments of Health and Education. This ongoing collaboration is supported by the Furman Initiative for the Interface of Education and Psychiatry of the American Academy of Child and Adolescent Psychiatry, and was held at NYU's Leonard N. Stern School of Business.

The meeting included a renowned group of program development and policy experts, from UCLA's School Mental Health Project, University of Maryland's Center for School Mental

Health Assistance, Yale Child Study Center, University of Pittsburgh Medical Center and the Youth and Family Center of Dallas Public Schools.

In addition to promoting improved access to quality care and preventive services at a local level, the Child Study Center will also prepare a resource kit consisting of videotaped segments of our meeting, written program description, a guide to program specialists, etc. This kit will be distributed so that other centers can benefit from the experience and knowledge gained by the NYU School Partnership School-Based Mental Health program. The Child Study Center will Continue to work closely with local officials to develop innovative models that meets local needs for implementation on a pilot basis in Fall 1998.

Parenting Institute

See attached document

ParentCorps *(Program in Development)*

See attached document

Young Adult Program

The Young Adult Program at the New York University Child Study Center is an intensive psychiatric inpatient program which serves the mental health needs of the often-neglected population of 13 to 24 year-olds. Adolescence and the beginning of adulthood is a developmental phase fraught with many stresses -- starting college, pursuing career goals, forming relationships with friends and significant others, coping with changing family roles. These stresses can precipitate life-threatening illnesses and behaviors such as depression, anxiety disorders, substance abuse, eating disorders, adjustment disorders and even suicide. Serious psychiatric illnesses such as schizophrenia and bipolar disorder can also have their onset during this time. Experts from NYU in the fields of psychiatry, psychology, social work and nursing, draw on leading-edge therapeutic techniques and breakthrough pharmacological research in treating patients. Emphasizing rapid assessment and individualized attention, this team of experts strive to restore balance to a young life in turmoil.

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550 First Avenue New York, NY 10016
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• clinical care • advanced training • scientific research • educational outreach • prevention •

Child Study Center
Research

Funded Research

Multimodal Treatment Study of Children with ADHD (the MTA Study)

The MTA Study, a 7-site NIMH funded cooperative agreement, is the largest clinical trial conducted to date with children. Using a parallel-group design, 579 rigorously diagnosed children with ADHD age 7-9 were randomly assigned to four treatment conditions: (1) Medication-only; (2) Psychosocial-only; (3) Combined (medication and psychosocial); or (4) Assessment-and-Referral (a community control) condition. All but the latter were treated intensively for 14 months, with assessments for all subjects at baseline, 3, 9, 14, and 24 months (10 months post-treatment). Additional funding supported the collection of a Local Normative Comparison Group (LNCG) drawn from the same schools as ADHD children. WE ARE CURRENTLY FUNDED TO DO A ONE-YEAR FOLLOW-UP BEYOND THE 24-MONTH POSTTREATMENT PERIOD. Analyses of outcome data are currently underway. It is anticipated that the results of this study will have major public health implications regarding the treatment of children with ADHD.

Funding Source: *National Institute of Mental Health*
Direct Funds:$643,775 *Indirect Funds: $222,801*

We recently submitted a competing continuation application to extend the follow-up to assessments at 36-, 60-, and 84-months after treatment. The proposed 5 Year follow-up study has 4 major aims. **Aim 1** is to track the persistence of intervention-related effects as the MTA sample matures into mid-adolescence, including subsequent mental-health and school-related service utilization patterns as a function of MTA treatment experience (treatment assignment) and outcome (degree of treatment success at 14 mo.). **Aim 2** is to test specific hypotheses about predictors, mediators, and moderators of long-term outcome among children with ADHD (e.g., comorbidity; family functioning; cognitive skills; peer relations) that may influence adolescent functioning (either independently of or through initial treatment assignment and/or 14-month treatment outcomes); and to compare how these predictors, mediators, and moderators are similar or dissimilar within the LNCG. **Aim 3** is to track the patterns of risk and protective factors (including their mediation or moderation by initial treatment assignment and/or outcome) involved in early and subsequent stages of developing substance-related disorders and antisocial behavior. **Aim 4** is to examine the effect of initial treatment assignment and degree of treatment success on later academic performance, achievement, school conduct, tendency to drop out, and other adverse school outcomes.

Funding Source: *National Institute of Mental Health*
Direct Funds Requested:$1,578,751 *Indirect Funds Requested: $570,799*
Principal Investigator: Howard Abikoff, Ph.D.

Research Units in Pediatric Psychopharmacology (RUPP) Studies

NYU Child Study Center, in collaboration with NYS Psychiatric Institute, is one of seven sites which has received NIMH funding in support of specific clinical pediatric psychopharmacology trials and the infrastructure to support the conduct of additional trials.

Two trials are currently underway. The first, supported by NIMH funds, is a double-blind, placebo controlled random assignment study of the effectiveness of the SSRI fluvoxamine (Luvox) in children with anxiety disorders. This short-term study is followed by an open label long-term study. The long-term study is designed to address three related questions: 1.) What is the continuing efficacy and safety of fluvoxamine in subjects who were responders to fluvoxamine in the short-term study? 2.) What is the safety profile and rate of response in subjects who received placebo in the short-term, controlled study? 3.) What is the safety and efficacy of a second SSRI (fluoxetine) in subjects who were non-responders to fluvoxamine in the short-term study?

The second trial is an industry supported study of the efficacy of buspirone patch in children with ADHD. The first phase of the trial is a short-term double-blind, placebo controlled random assignment study. This is followed by an open label study which is intended to evaluate the long-term effectiveness of the patch. We anticipate that two other industry supported psychopharmacology trials will begin shortly. Each will evaluate the efficacy of new compounds in the treatment of children and adolescents with ADHD.

Funding Source: *National Institute of Mental Health*
Direct Funds: $151,592 *Indirect Funds: $79,721*
Bristol Myers Squibb
Direct Funds: $111,490 *Indirect Funds: $47,781*
Principal Investigator: Howard Abikoff, Ph.D.

Prospective Follow-Up of Child Psychiatric Inpatients

This research study tracks youngster's clinical course after discharge from an in-patient psychiatric hospital. The objective of this study is to gain a better understanding of postdischarge service needs, changes in service needs in the follow-up period, and how accurately hospital clinicians judge prognosis and service needs.

Funding Source: *National Institute of Mental Health*
Direct Funds: $100,000 *Indirect Funds: $65,000*
Principal Investigator: Joseph Blader, Ph.D.

Early Primary Prevention of Conduct Problems

Dr. Miller is currently the recipient of two large federally funded grants that focus on the development and prevention of aggressive and antisocial behavior. She is the principal investigator on a five-year grant entitled *Early Primary Prevention of Conduct Problems* funded by the National Institute of Mental Health (NIMH). This is a large-scale randomized prevention trial for urban preschoolers at familial risk for antisocial behavior. This study tests an innovative family-based intervention for 100 preschoolers who are the siblings of convicted delinquents. Families are screened through the Manhattan and Bronx Family Courts and randomized to intervention and control conditions. All families are assessed at baseline, post-intervention, and at 6 and 12 months post-intervention. Assessments include ratings by parents regarding child behavior problems and social competence, parenting skills, parenting stress and support, observations of parent-child interactions in the lab and in the family's home, observations of peer interactions, psychiatric assessments of children and their parents, and tests of child intellectual functioning. Follow-up evaluations will also include assessments

of child functioning at school. Sibling functioning, at home and at school, is also assessed. The intervention includes weekly parenting skills training groups, a peer skills group for the preschoolers, and a social skills training group for their 5 to 12 year old siblings. There are 26 2-hour sessions provided over an 8 month period (October through May). Intervention families also receive 15 biweekly home visits over the 8 month period. Families also receive 6 booster sessions in the Fall of the following year. Control families receive assessments only. This study will not only contribute to our understanding of the early development of aggressive behavior in young high-risk children, but it will also provide empirical support for a comprehensive intervention program that can be applied to preschool children in a variety of different settings (e.g., Head Start). (To Commence at NYU Child Study Center in August)

Funding Source: *National Institute of Mental Health*
Grant: $1,710,972 *Indirect Funds: $1,112,131.80*
Principal Investigator: Laurie Miller, Ph.D.

Cross-Generational Influences on the Development of Aggression

Dr. Miller is co-principal investigator on a longitudinal study, recently funded by the National Institute for Children's Health and Development (NICHD), examining the cross-generational influences on the development of aggression. This study is a follow-up to a study initiated in 1960 of an entire population of over 800 third graders living in Columbia county, New York. This unique data set has already contributed to the scientific understanding of the development of aggression, including the stability of aggression and the influence of media violence on aggressive behavior. The data set has also been used to support important changes in social policy, such as the introduction of legislation to reduce violence on children's television. This study will commence in September, 1998.

Funding Source: *National Institute of Mental Health*
Grant: $1,7000,000 (Study conducted at University of Michigan)
No direct funds to NYU Child Study Center
Co-Principal Investigator: Laurie Miller, Ph.D.

Minority Research Grant

Dr. Miller has a four-year NIMH-funded training grant for minority researchers for Lisseth Rojas-Flores. Ms. Rojas-Flores and Dr. Miller are conducting a randomized pilot study of a parenting skills training program with Spanish-speaking preschoolers enrolled in a Head Start program. Forty families attending Head Start are randomized to Parenting Skills Training and general skills groups. All parents receive pre- and post-intervention assessments, including ratings by parents, Head Start teachers and Home Visitors, and videotaped observations of parent-child interactions. The intervention is conducted in Spanish and includes 8 1½ hour sessions. Data from this pilot study will serve as the basis for a grant application for a large-scale randomized preventive intervention trial with Head Start children. (To Commence at NYU Child Study Center in August)

Funding Source: *National Institute of Mental Health*
Grant: $164,553 *Indirect Funds: $106,959.45*
Principal Investigator: Laurie Miller, Ph.D.

Maternal Depression on Parent-Child Interactions and Child Disruptive Behavior

Dr. Miller is the recipient of grants from the National Association for Research on Schizophrenia and Depression and Pfizer Pharmaceuticals to study the influence of maternal depression on parent-child interactions and child disruptive behavior. (To Commence at NYU Child Study Center in August)

Funding Source: *National Association for Research on Schizophrenia and Depression*
Grant: $60,000 *Indirect Funds: $39,000*

Funding Source: *Pfizer Pharmaceuticals*
Grant: $43,750

Principal Investigator: Laurie Miller, Ph.D.

Grants in Preparation

Writing Disorders and Transition to Middle School Research

The Child Study Center is preparing a grant to study developmental writing disorders and how troubles with written language expression, organizational skills, and working memory may be partly responsible for the common finding of declines in academic motivation and performance following the transition to middle school. Changes in children's psychosocial well being other than academic adjustment will be evaluated, using clinically-relevant assessment methods to determine which children are at risk for distress and dysfunction during this critical preadolescent period.

Potential funding source: National Institute of Child Health and Human Development
Principal Investigator: Joseph Blader, Ph.D.

Disruptive Behaviors Research

The Child Study Center is preparing a grant to fund a study of combined pharmacotherapy for the treatment of disruptive behavior disorders, in conjunction with RUPP facilities. A rich source of preliminary clinical data on this topic comes from the database of daily ratings and behavioral symptoms monitoring from an inpatient psychiatric service; this database spans seven years and 900 patients, most of whom were treated with more than one psychotropic agent simultaneously.

Potential funding source: National Institute of Mental Health
Principal Investigator: Joseph Blader, Ph.D.

child study center

The Child Study Center is a multi-specialty program at New York University Medical Center and NYU School of Medicine. It is the first program in the New York area to offer complete child and adolescent psychiatric care that is fully integrated with scientific research and education. Our research initiatives advance our understanding of the causes and treatments of child mental disorders. In collaboration with public and private school systems and other social organizations, the Center provides innovative preventive resources to families. These outreach programs translate scientific research into everyday skills for parents and educators, and into the everyday practice of pediatricians and mental health professionals around the country.

The Child Study Center's main divisions are:

- Clinical Care
- Advanced Training
- Research
- Educational Outreach & Prevention

Clinical Care

The Child Study Center's premier clinicians put into practice the knowledge gained through extensive research. The result is care that incorporates the most up-to-date knowledge about the causes, symptoms and treatments of mental disorders. Services include:

Attention Deficit/Hyperactivity Disorder Service
Research and clinical services focusing on the diagnosis and treatment of AD/HD

Infancy & Early Childhood Development Program
Services for children ages 0-6, with developmental delays and behavioral difficulties

Institute for Learning and Academic Achievement
Evaluations and treatment for learning disabled and gifted students

NYU Summer Program for Kids with AD/HD
Comprehensive therapeutic program for children with AD/HD

Port Washington Alternative Learning Program
School-based mental health program for at-risk adolescents

Young Adult Inpatient Program
Intensive inpatient psychiatric program for adolescents and college-age adults

Advanced Training

The Child Study Center is a national training center for mental health professionals. In collaboration with NYU School of Medicine, the Child Study Center offers a fully-accredited graduate training program in child and adolescent psychiatry and psychology. The program is under the direction of a multi-disciplinary faculty of behavioral scientists and clinicians. NYU's child and adolescent psychiatry faculty is one of the largest in the United States and has expertise in numerous subspecialty areas. The goal of the program is to train and prepare the next generation of mental health professionals to meet the demands of a complex and expanding field and to translate current and on-going research into advanced clinical care and effective treatments.

The Child Study Center is an indispensable resource for parents, educators, and child-health professionals. By advancing our understanding of the causes and treatments of mental disorders, the Child Study Center serves not only the children of New York, but also all young people in America.

In the summer of 1998, the Child Study Center will occupy a new 20,000 square-foot space. Our new home will be a state-of-the-art center located at 33rd street and First Avenue directly across from the NYU Medical Center. This space will house all the facilities of the Child Study Center within a child and family-friendly environment and will enable researchers and clinicians to communicate in an environment that will foster new ideas and understanding of the risks and treatment of childhood mental illness.

The Child Study Center is seeking charitable contributions to help build the Center into the premier institution for child and adolescent psychiatry. Please fill out the response card located on the back of this brochure and join the Child Study Center today. Donations can truly make the difference in helping thousands of children with learning, behavior, emotional, or mental disorders to recapture their childhood and, with health and confidence, address their futures.

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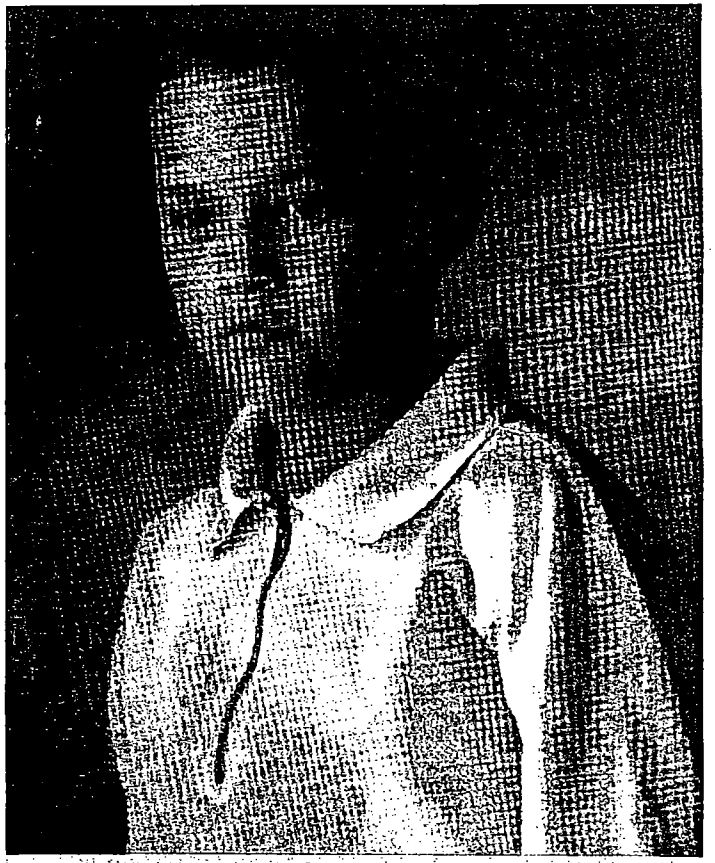

child study center

New York University

"We live in a time when scientific knowledge of the brain is growing at an unprecedented rate. Our goal is to apply that knowledge in earnest. The children and families of New York now have a Child Study Center where they can receive science-based, research-driven, state-of-the-art care in child and adolescent psychiatry."

–Harold S. Koplewicz, M.D.
Director, Child Study Center

"The Child Study Center is one of the pinnacles of excellence that makes our medical school and healthcare system world-renown."

–E. John Rosenwald, Jr.
Chairman, Board of Trustees
NYU Medical Center
NYU School of Medicine

"I have my child back!"

"Parenting has never been so much fun."

"My child is finally a winner, and more importantly he thinks so too."

"At last, my child is happy and has friends."

"We needed a Child Study Center years ago. We're in good hands."

Research

The Child Study Center offers an enriched environment for scientific research in new treatments and also in the risks, predictors, and causes of childhood mental disorders. The Center's psychiatric investigators benefit from exciting collaborations with researchers and scientists of the NYU School of Medicine, NYU School of Education, the NYU Center for Neural Science, and the Nathan Kline Psychiatric Institute.

The Center is one of only four federally-funded Research Units for Pediatric Psychopharmacology (R.U.P.P.) in the nation to offer free clinical trials for children and adolescents with psychiatric disorders.

Educational Outreach & Prevention

The Child Study Center's educational outreach and prevention programs teach thousands of parents, educators, pediatricians, and other mental health professionals about normal child development and how to promptly recognize and intervene when a child needs help. The Child Study Center provides educational programs directly in schools, hospitals, community centers, and other convenient locations. Programs include:

Parenting Institute

- Provides free lectures and classes about child development
- Trains parents and educators to identify and intervene when a child needs help
- Encourages dialogue between caring adults and mental health professionals through an interactive World Wide Web site (in development)
- Publishes the *Parenting Letter* to educate families about parenting issues (in development)

Getting a Good Start

- Provides a free two-hour class for all new parents of infants born at NYU Medical Center
- Trains parents to tune into their infant's moods and needs
- Helps parents design a daily schedule
- Helps parents develop a healthy relationship with their child

NYU-School Partnership

- Provides an on-site team of mental health professionals in public and private schools
- Develops curricula in collaboration with the NYU School of Education
- Trains educators to identify high-risk students
- Helps improve teachers' classroom management skills

Child Study Center Letter

- Newsletter with a circulation of 25,000
- Translates results of the latest research findings and provides the most relevant clinical information for educators, pediatricians, psychologists, psychiatrists, and other mental health professionals

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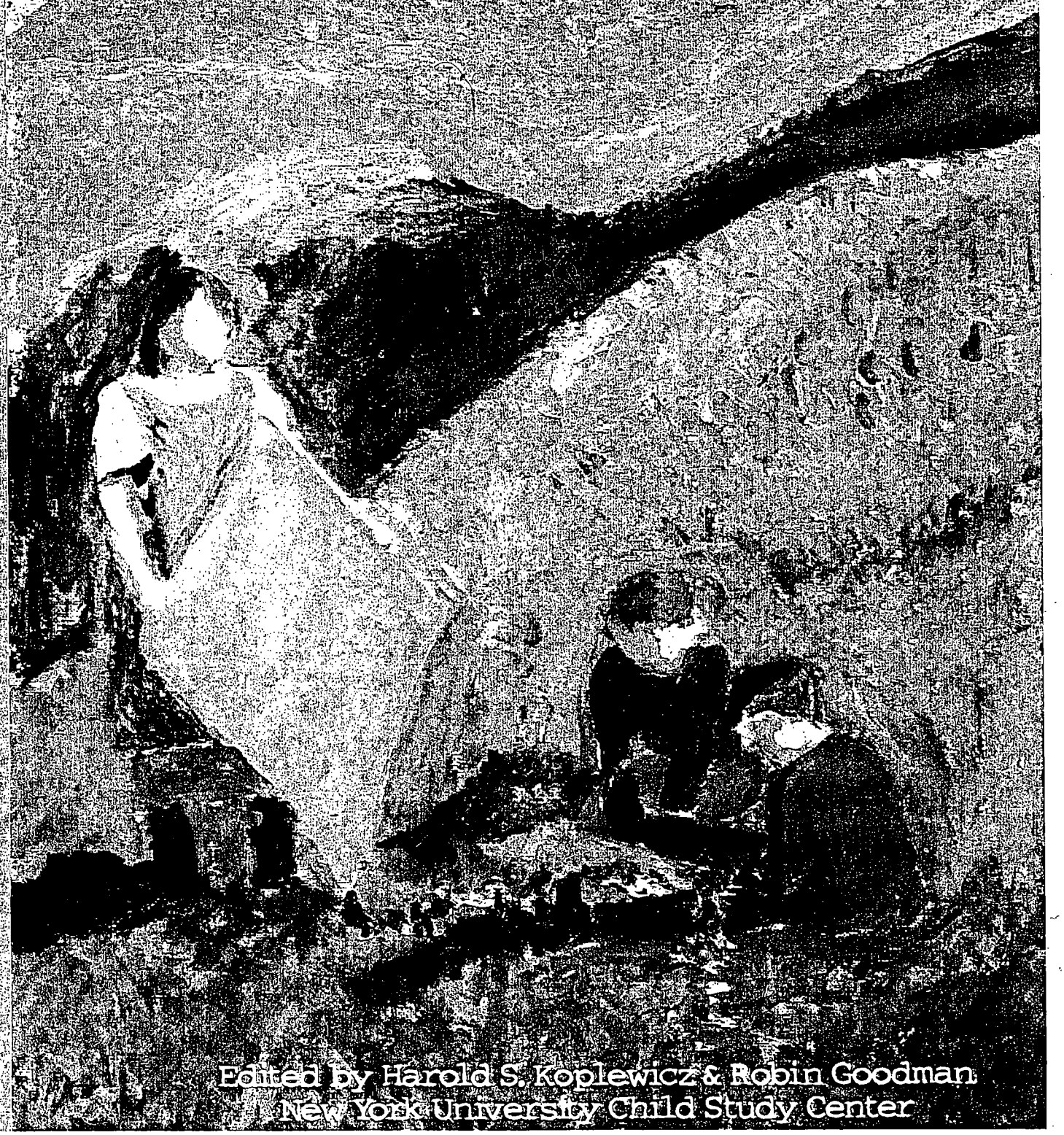
CHILDHOOD REVEALED

Art Expressing Pain, Discovery & Hope



Edited by Harold S. Koplewicz & Robin Goodman
New York University Child Study Center

CHILDHOOD REVEALED

CONTENTS

By Gabrielle Carlson, M.D. Professor of Psychiatry and Pediatrics and Director of the Division of Child and Adolescent Psychiatry, New York State University School of Medicine at Stony Brook

ANDY, ELEVEN, DOESN'T KNOW WHAT'S WRONG. HE CAN'T SEEM TO GET OUT OF BED IN THE MORNING, often has trouble falling asleep at night, and nothing his parents do or say can lift his lethargy: "It could be a perfect spring day," his mother says, "but he's not interested in joining the other kids playing outside." Andy doesn't even care to see his two best friends, and when they call he tells his mom he has a stomachache or a headache—again. He's no longer excited about hockey, even though last year he was the team's highest scorer. In fact, most of the time, Andy feels like crying, but he's careful not to let anyone know because he doesn't want to worry his parents. They've had enough on their minds, he figures, since his Dad lost his job last year. Although the pediatrician has ruled out any physical illness, Andy has no appetite and he's as skinny as his seven-year-old sister. Recently, when a teacher tried to coax a smile out of him, Andy burst into deep, heaving sobs so uncontrollable that his mother had to come to school and take him home. "I just feel like a piece of me inside is missing," was all he could say.

Everything bothers fourteen-year-old Stephanie. "She wakes up in the morning mad at the world," reports her mother. "We can't have a conversation without her sneering and snapping." Stephanie has always been a demanding, high-maintenance child, but in the past year her impatience, negativity, and defiance—especially at home—has worsened. At first, her parents chalked up the sullen attitude and the slammed doors to typical teenage turmoil, but they're getting increasingly worried. Always a top student, Stephanie now rarely opens a book and spends her afternoons and evenings locked in her room, refusing to tell her parents what's bothering her. "I feel terribly guilty saying this," admits her mother, "but in a way, I'm a little relieved. So much of the time, I can't stand to be around her." Stephanie's father agrees: "I think it's high time she just snapped out of this and started taking some responsibility around here."

Female, 16 years old. **Heroin,** 1997. Conte crayon and charcoal, 18 x 24"

The circles are like rocks . . . cold and dead. One beautiful thing grows out of the deadness, which shows there is still life. It shows how beautiful things can come out of deadness. That's how heroin is. It's the pretty part, but it can also be the deadness. It's depression.

The trouble is, neither Andy nor Stephanie can snap out of it. Though their symptoms are different, Andy and Stephanie both suffer from Major Depressive Disorder. It's not surprising that neither child's parents realized what was causing their offspring's problems. Even today, depression in children often goes unrecognized—and, as a result, untreated. In fact, until 1980, the psychiatric community had no official set of diagnostic criteria for this disorder, since doctors and lay people believed that emotional upsets in children were fleeting and therefore did not need to be taken too seriously. Conventional wisdom held that children couldn't be depressed because they hadn't experienced enough of life.

Now we know that children have no such immunity. Depression as a disorder is rare in youngsters under the age of twelve, affecting just 1 to 2 percent of children five to eleven years old, and equally in boys and girls. Children do, however, show signs of depression, ranging from a handful of symptoms to full-blown psychosis. By the time they hit puberty, an estimated 8 percent of younger people twelve to eighteen (nearly twice as many girls than boys) suffer from Major Depressive Disorder, a spiraling sadness so deep the gloom never leaves them. But depression in children, as in adults, does not have any one face. Like grownups, youngsters may display an array of seemingly contradictory symptoms. They may be quiet, lethargic, and withdrawn, or irritable, belligerent, and angry. That said, they do share a common denominator—unshakeable feelings of helplessness and hopelessness rob their lives of joy and they may become so self-critical that they contemplate—or even try—to kill themselves.

An Elusive Diagnosis

Yet depression in children is notoriously difficult to diagnose for many reasons, not the least of which is the fact that the word is bandied around so frequently and arbitrarily. After all, everyone gets "depressed" at one time or another: When we gain five pounds and can't lose them; when we fail to get the job we want. Even kids use the term colloquially: "I got a C on the history midterm—I'm so depressed," your high school sophomore will say. However, when doctors use the term, they mean more than a temporary sadness or disappointment. Clinical depression is a constellation of symptoms that occur over a specific period of time; have a definite onset, duration and ending; and impair a child in some profound way.

Even these factors can vary, contributing to the elusiveness of the diagnosis. Some youngsters suffer from what's known as dysthymic, or minor, depression, a kind of low-grade sadness that lingers for months or years. Quiet and shy, they may be dubbed a "good" child, when in fact they are depressed. Conversely, an aggressive youngster, summoned daily to the principal's office for punching his classmates, may be labeled a behavior problem and disciplined more harshly, when what he really needs is help to combat depression. What's more, children may display symptoms of depression from the time they're two or three years old, or they may have a sudden change in behavior and attitude that appear to come out of the blue.

Further compounding the difficulty is the fact that depressed kids often struggle with other problems—from anxiety, eating, or conduct disorders, learning disabilities, or bipolar depressive disorder—that must be ruled out before a definitive diagnosis can be made.

When Kids Are Sad—And Mad

Why is one child emotionally resilient while others buckle under the first setback? Just as there's no one cause of depression in adults, a combination of factors—some genetic, some social—can trigger depression in young people, and they're all exacerbated by stress, particularly during the teen years. Studies reveal a strong family link, most likely an inherited abnormality in brain chemistry, that makes a person more vulnerable to illness. Children of depressed parents have a higher risk of developing depression, recover more slowly from depressive episodes, and are more likely to have a recurrence. A depressed child can't simply "buck up" and will away her depression, as Stephanie's Dad insists. Indeed, too often, we waste valuable time and psychic energy wondering what causes a depression when instead we could be treating it.

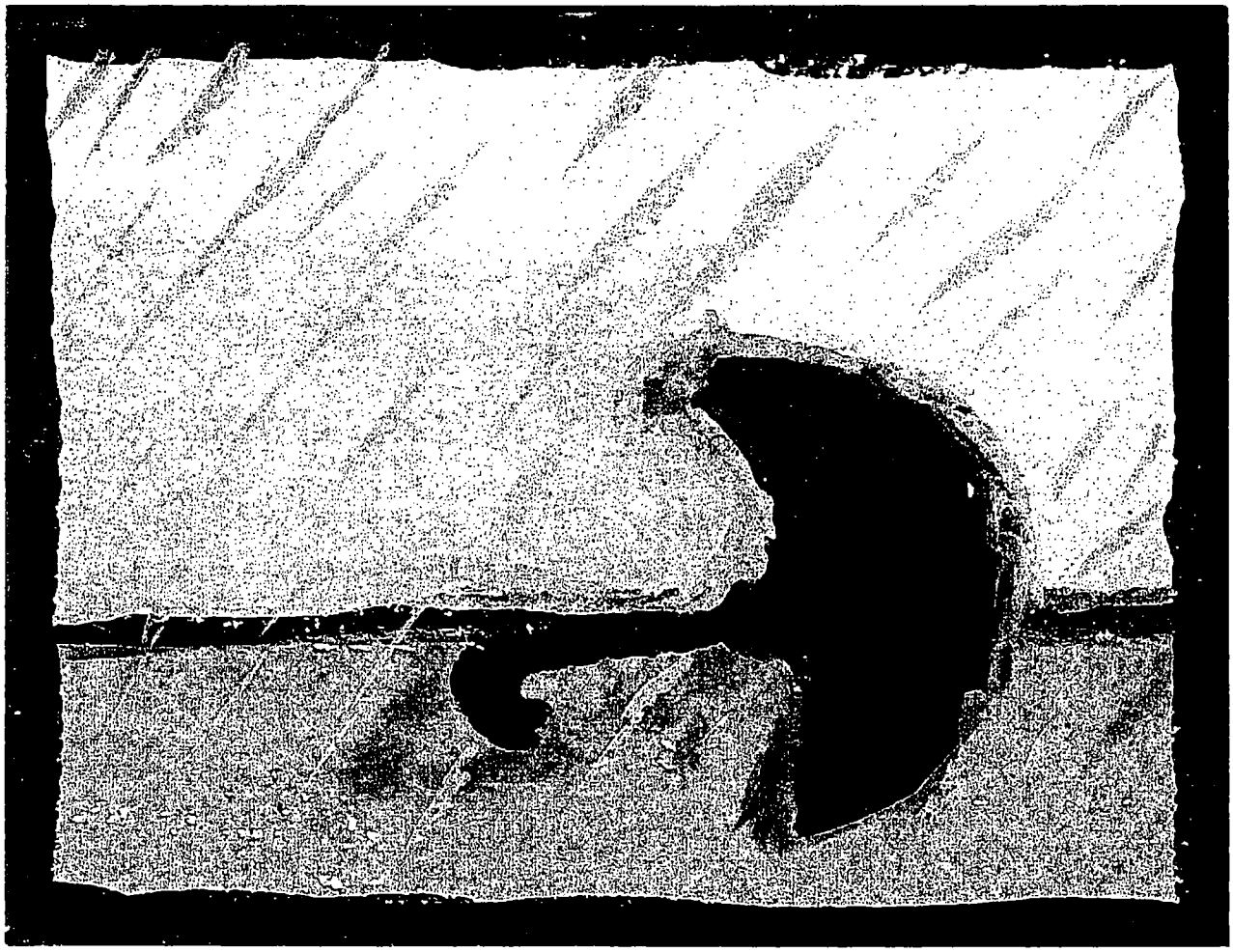
Still, for parents, the diagnosis is a harsh blow and they may continue to deny it out of guilt and fear. "I can't help thinking I've failed her," Stephanie's mother concedes, "that I've failed as a parent." In fact, depression is not only no one's fault, it's highly treatable—the sooner, the better. Even mild episodes of childhood depression can be harbingers of more serious problems later. Doctors now use a combination of psychotherapies—including play and cognitive therapy in individual or family counseling—as well as medication to help depressed kids feel more in control of their own lives.

The Warning Signs

I always tell parents: One swallow does not a springtime make. Just because your child has one or even several of the symptoms listed below doesn't mean he or she has a serious problem, but it does mean you need to trust your gut and get help. The following are important clues:

Depressed or irritable mood most of the day, most of the time
Lack of interest or pleasure in activities formerly enjoyed
Significant weight loss or gain; change in eating patterns
Inability to concentrate or focus on work or other activities
Feelings of worthlessness, hopelessness, and guilt
Continued agitation, sluggishness, or fatigue
Inability to fall or stay asleep
Recurrent thoughts of death or suicide; increase in risk-taking behaviors

If these problems are persistent, pervasive, or impairing, call your pediatrician, school psychologist, a medical school or teaching hospital, or the American Academy of Child and Adolescent Psychiatrists for a referral to a specialist in child and adolescent psychiatric problems. Depressed kids see the world through cracked glasses. By educating yourself about emotional disorders, pushing and prodding until you get the answers you need, you can help your child put his life, and his future, into better perspective.



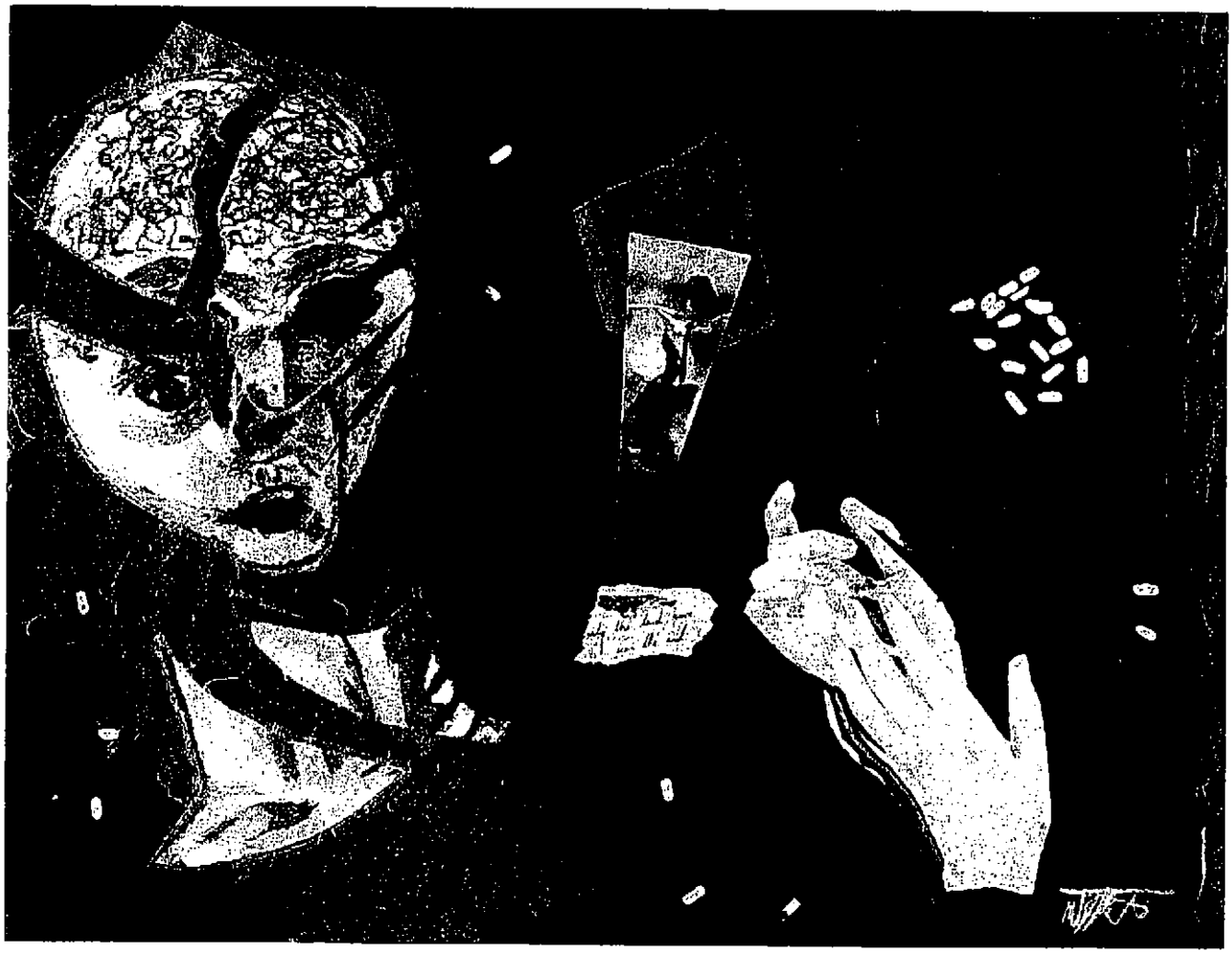
Female, 14 years old. **Untitled,** 1993. Watercolor, 4½ x 5¾"

I remember it was raining. We were in Portland.
Mom had thrown a knife and I saw her using cocaine with her friend.

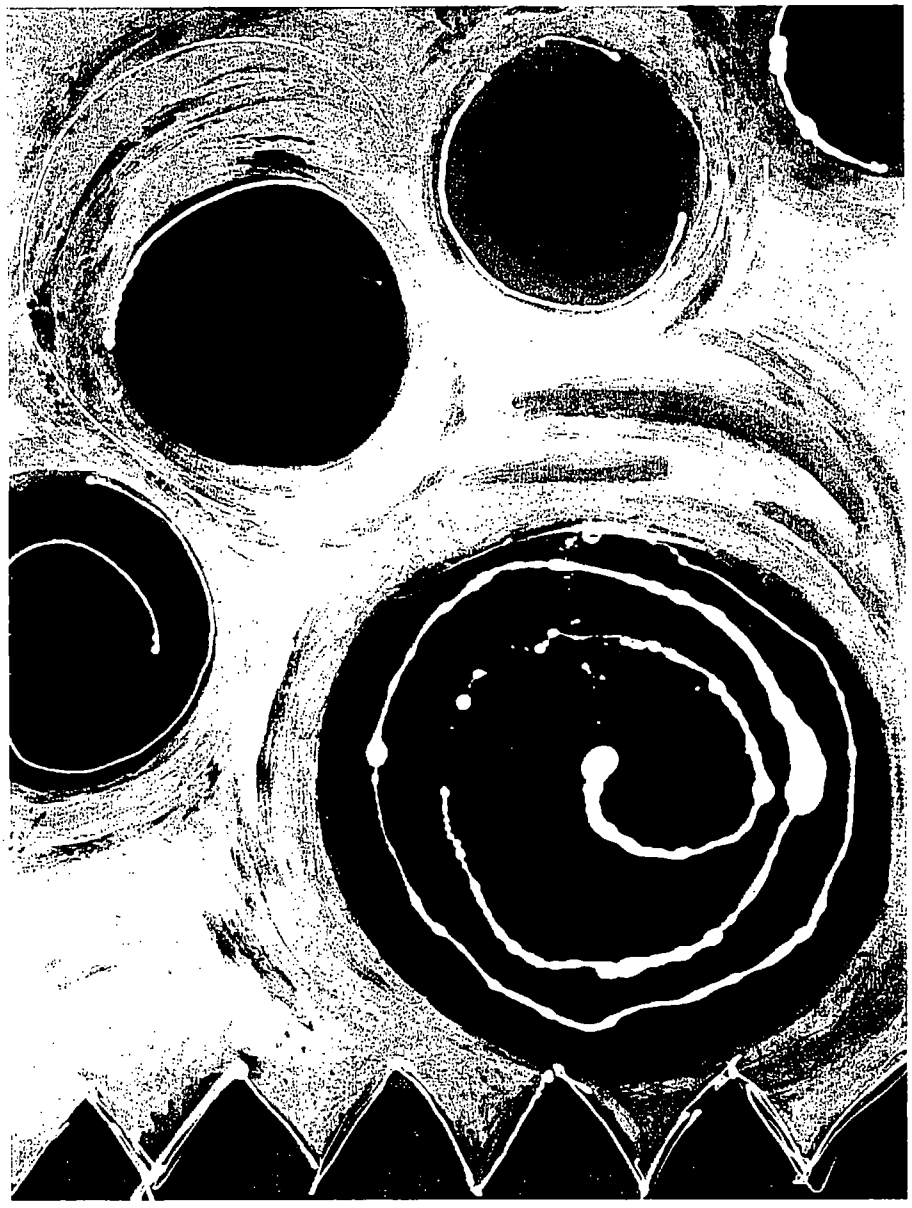
An umbrella held sideways isn't much help in a storm. It must be hard to hold onto an umbrella—or hope—when you see your mom using drugs. I look at this and wish I could help this child hold onto something reliable for protection.

Male, 10 years old. **What Scares Me Most,** 1999. Felt marker, 12 x 17"

Young children and adults don't see depression the same way. Being scared can make a child afraid that bad things will happen. Imagine how helpless you would feel if you thought this strange creature, with its pointy teeth, lurked nearby. At any age, unhappiness can be menacing.



Female, 14 years old. **Untitled,** 1997. Mixed media, 20 x 15"



Female, 17 years old. **My Bright Circles**, 1997. Acrylics, 5½ x 8"

My bright circles are about me and how I'm surviving my illness.
The bigger the circles get the better I am doing.
Life's a never-ending circle and I just hope to live through it.

Anxiety can seem so circular. You might start with a small worry,
but then your mind feeds on it until the problem grows out of control.
Sometimes the trick is to keep the ball of worry contained and learn to live with it.

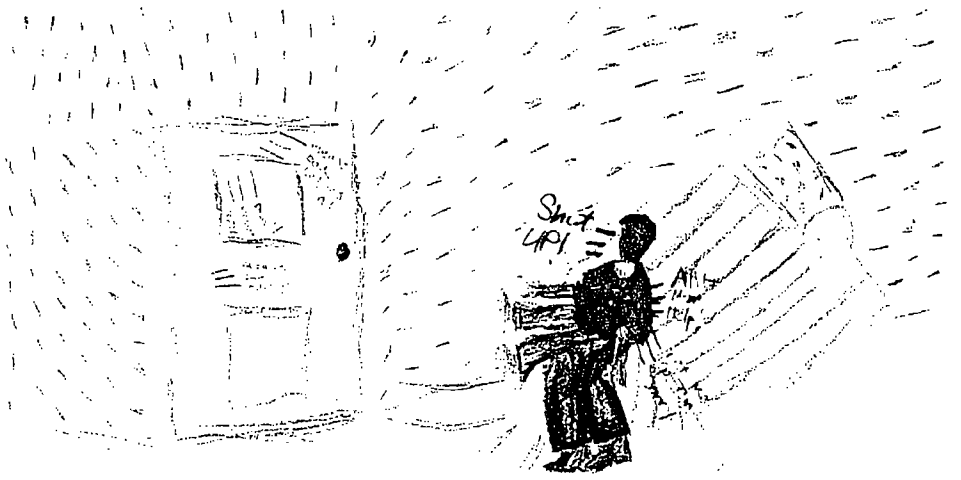
Schizophrenia. Female, 15 years old. **Rebirth of the Messiah!,** 1997. Acrylic and pencil, 16 x 20"

The messiah he takes me higher, halos in the wind it blows
where it stops nobody knows, it just goes and blows and blows.

Delusions of grandeur and religious dogma often become the organizing structure for life when you have schizophrenia. With all that blue in the heavens, you wonder if the wind and the sky can make up for feeling rootless.

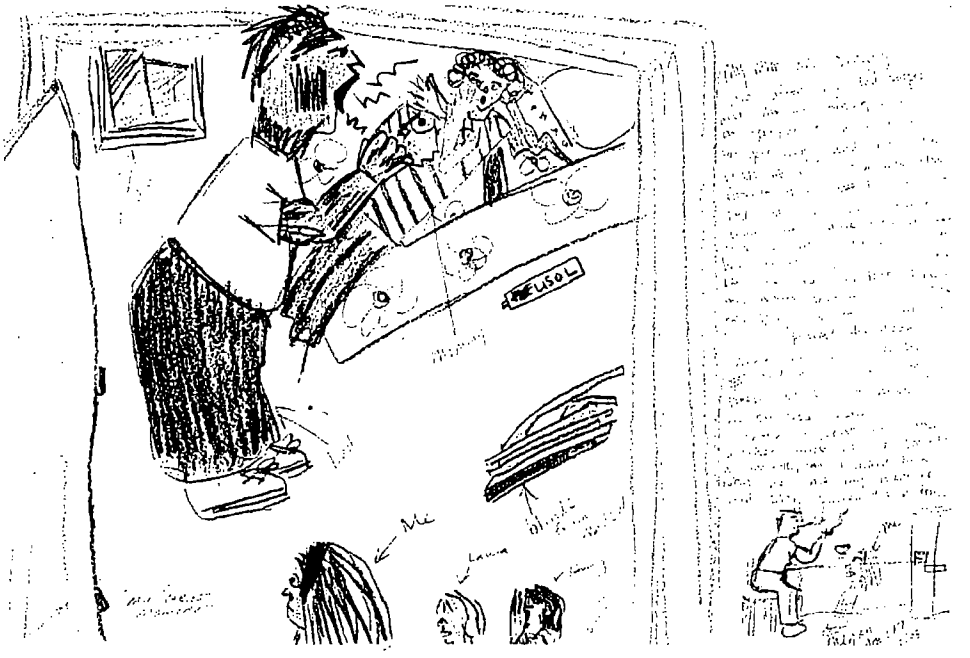
Bipolar (manic depressive illness).
Male, 11 years old. **Self-Portrait**, 1998. Watercolor, 11 x 14"

Children diagnosed with schizophrenia can have lucid, clear moments when they see the world like everyone else. At other times, however, the boundaries between the real and the fantastical can disintegrate and become blurred. The richness of color and activity that surround this self-portrait may suggest this child's world as either chaotic or exciting.

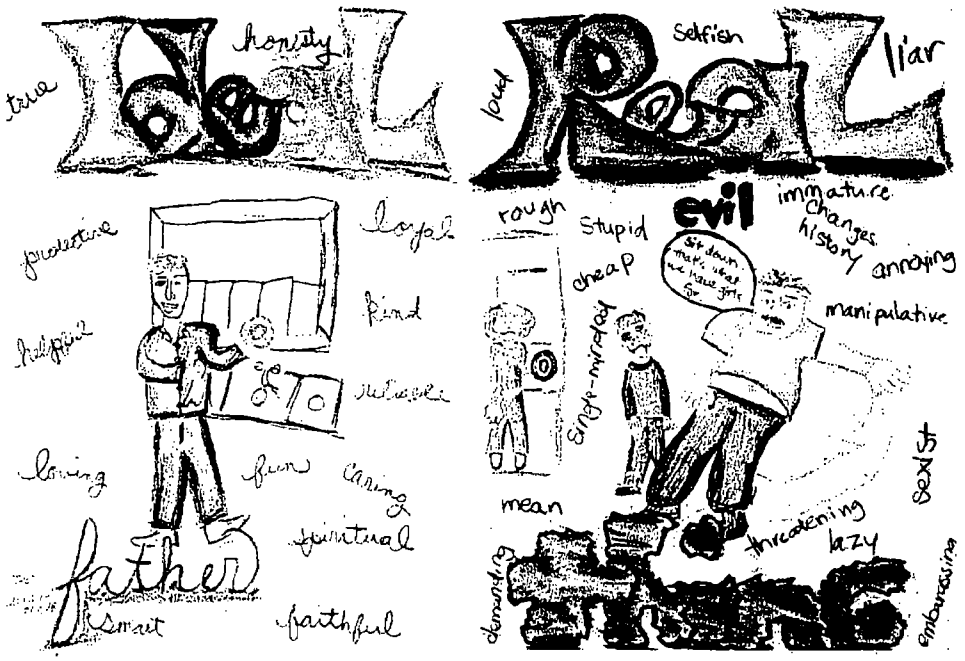


Female, 14 years old. **My Scariest Memory of My Dad,** 1997. Colored pencil and graphite, 12 x 18"

My mom was spraying Lysol after my Dad pooped and she was teasing him by spraying it in their room. He gets angry and throws blinds off the window onto the floor. He throws mom on the bed and tears her clothes down the middle, even through her bra. He is screaming at her at the top of his voice. He closes the door but I can hear my mom screaming that she was sorry. I wanted to help her so I opened the door. When he saw me he told us to go away. When we did not move, he left the room. Later I went into the kitchen while he was smoking a cigarette and I asked him why he hit my mom. He said she "pushed his buttons."

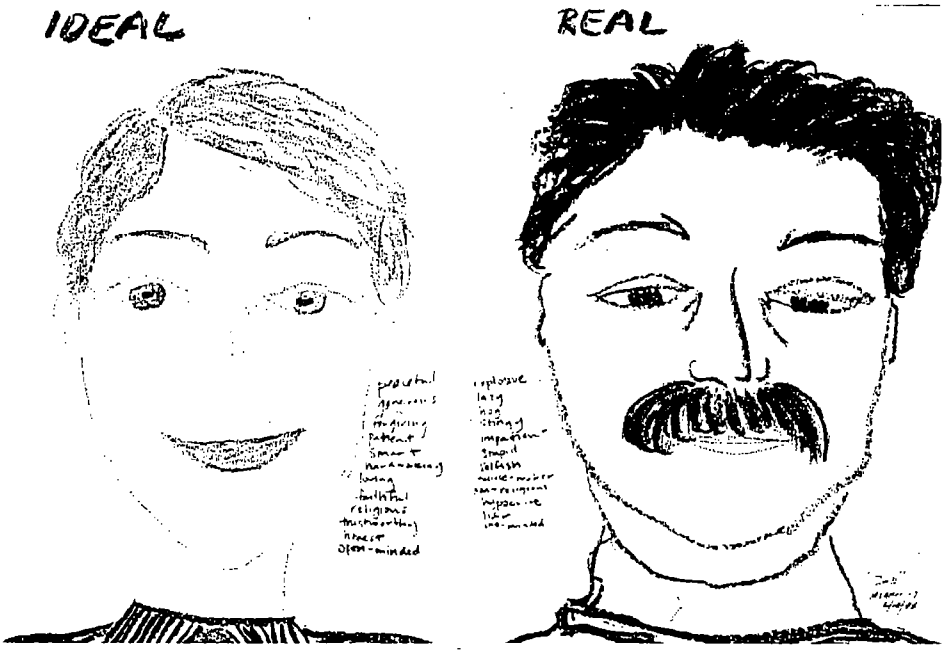


Female, 17 years old. **My Scariest Memory of My Dad,** 1997. Colored pencil and graphite, 12 x 18"



Female, 14 years old. **Ideal Dad vs. Real Dad,** 1997. Colored pencil and graphite, 12 x 18"

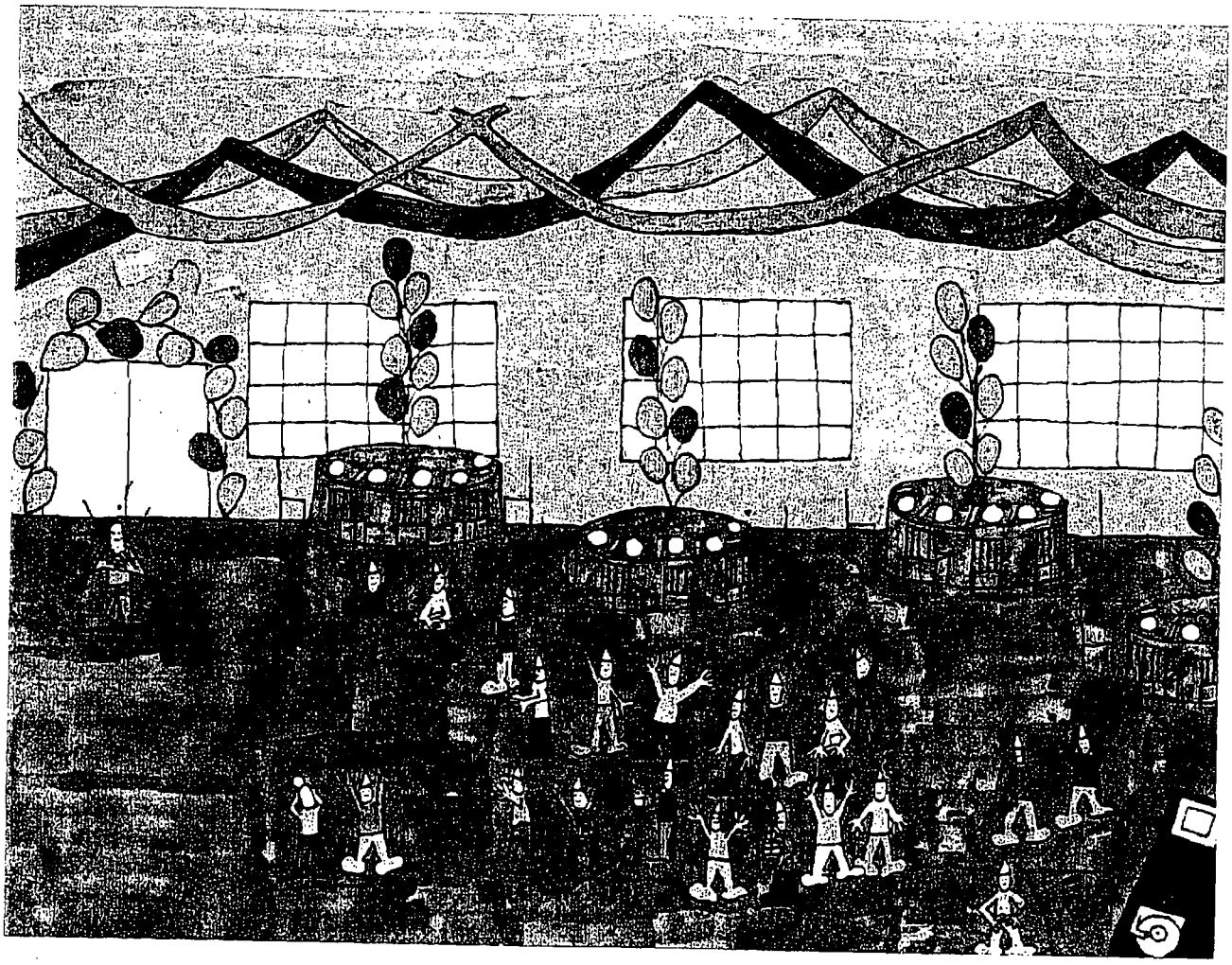
All of these images were made by children in one family experiencing the pain of divorce. A child's ability to hope and wish for the ideal can linger forever. Or, about the same amount of time that disappointment can last.



Female, 17 years old. **My Real Dad vs. My Ideal Dad,** 1997. Colored pencil and graphite, 12 x 18"

Cerebral palsy. Female, 15 years old. **Here Comes The Sun,** 1997. Tempera, 18 x 12"

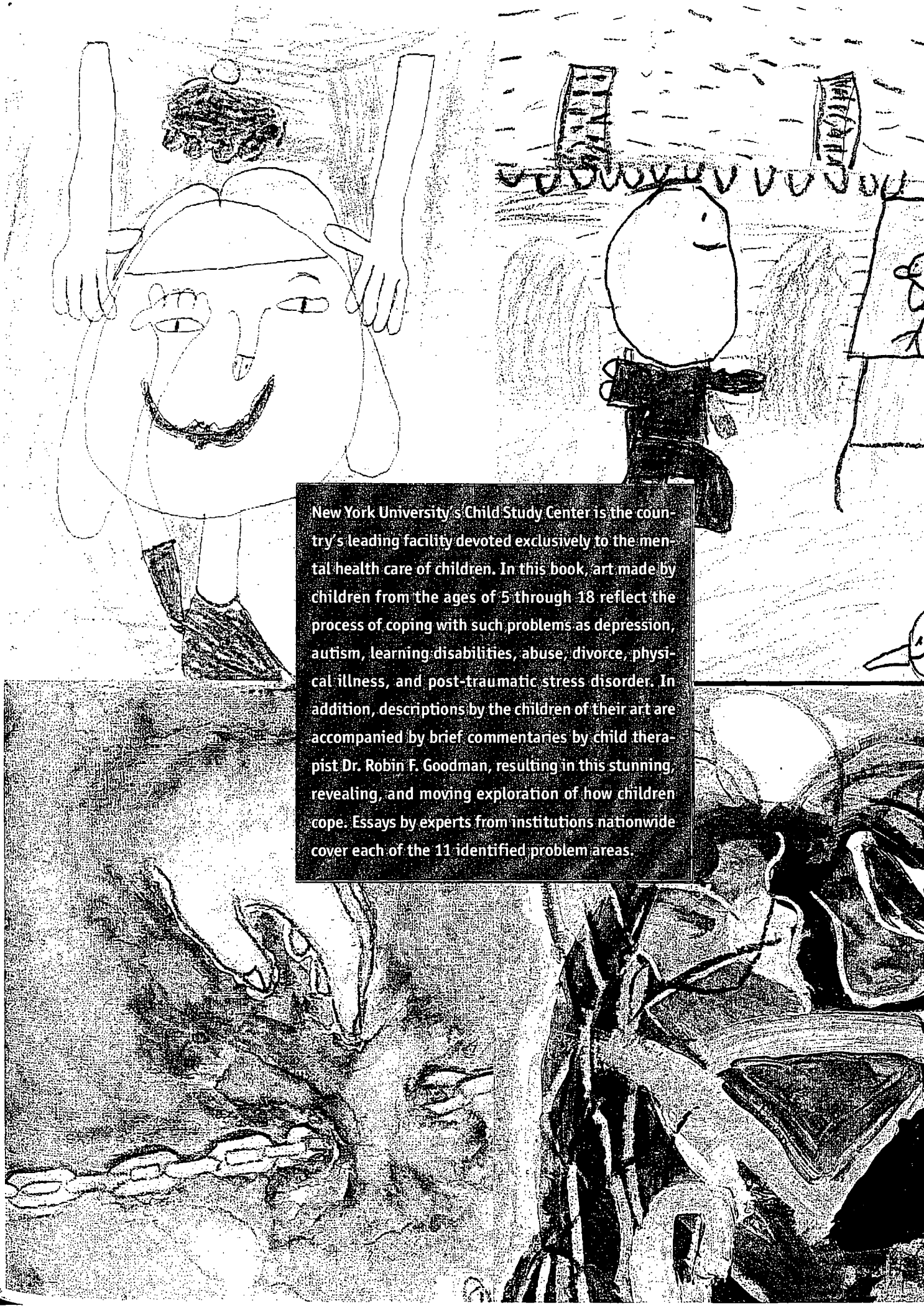
I love to express myself in art.
Although I am in a wheelchair and am physically limited, my art makes me feel free.
It helps me grow as a person. It has been one of my greatest accomplishments so far.



Cancer. Female, 16 years old. **Untitled,** 1997. Felt marker, 9 x 12"

The characters having the blowout are my "grapes." Last year I created them and I draw them all the time. The picture describes my spectacular "Sweet 16" party I had recently. It was so great to have a party especially for me. All of my friends came. It was great. I had a real rough year on chemotherapy.

It is a truly a testament to a child's resilience and ability to cope with illness that one night s party can wipe away a year's worth of pain.



New York University's Child Study Center is the country's leading facility devoted exclusively to the mental health care of children. In this book, art made by children from the ages of 5 through 18 reflect the process of coping with such problems as depression, autism, learning disabilities, abuse, divorce, physical illness, and post-traumatic stress disorder. In addition, descriptions by the children of their art are accompanied by brief commentaries by child therapist Dr. Robin F. Goodman, resulting in this stunning, revealing, and moving exploration of how children cope. Essays by experts from institutions nationwide cover each of the 11 identified problem areas.

Child Study Center

volume 3 • number 1 september / october 1998

education • clinical care • professional training • scientific research • school outreach • information update

Editor's Comment

The NYU Child Study Center has a new home! We now occupy a 20,000 square-foot, state-of-the-art facility located at 577 First Avenue (33rd St.) directly opposite Tisch Hospital. Our faculty and staff provide comprehensive research and clinical services to enhance the mental health of children, adolescents and their families.

Risk behaviors are the principal threat to the well-being and health status of adolescents in the United States, and are responsible for 3 out of every 4 deaths in this age group. In this issue of the *NYU Child Study Center Letter*, we review the impact and prevalence of risk behaviors, contrast normal developmental risk behaviors and those which may signify mental illness, discuss the potential preventive roles of professionals and parents, and describe research results which may serve as the basis for effective interventions. HSK

RISK BEHAVIORS IN ADOLESCENCE

Evening news bulletin, New York City, June 1998: *Three teen-agers were killed in the early morning hours when the car they were driving at high speed skidded off the road and slammed into a tree. All three were declared dead at the scene of the accident. Investigators found the safety belts in the car were unfastened at the time of the crash.*

Risk behaviors are the leading cause of morbidity and mortality in American youths between the ages of 12 and 21 years. Risk behaviors are the choices, actions, and events that threaten an adolescent's health. They increase the likelihood that he or she will experience physical or mental disability or death through illness or injury. The most significant risk behaviors include:

- Abuse of substances such as drugs, alcohol and tobacco
- Sexual activity
- Interpersonal violence
- Carrying weapons
- Self-harm and suicidal actions
- Health habits such as poor nutritional and eating practices, lack of exercise
- Failure to follow safety rules, to operate vehicles safely, and to use safety equipment

The most significant adverse outcomes of risk behaviors include:

- alcohol dependence
- drug addiction
- teen pregnancy
- sexually transmitted diseases
- accidental death
- homicide
- obesity
- heart disease

Classification of Risk Behaviors

Acute risk behaviors place a youth in immediate jeopardy of serious bodily injury. Behaviors that increase acute risk include careless use of vehicles, experimentation with illegal drugs or involvement in interpersonal violence. The adverse outcomes of these acute risk behaviors are so sudden and catastrophic that they draw the public's attention. Acute risk behaviors result in injuries, which may be either intentional (i.e., weapons use, suicide) or unintentional (i.e., biking accidents, car crashes). The differentiation of intentional from unintentional injuries can be difficult to make in individual cases.

Chronic risk behaviors involve the development of life habits that compromise a youth's well-being as they are practiced over an extended period of time. The adverse outcomes of chronic risk behaviors are insidious and do not gain the same high level of exposure as the tragic sudden deaths of teens resulting from interpersonal violence or accidents. The serious outcomes of chronic risk behaviors are further blurred by society's sanctioning of certain behaviors as desirable (i.e., junk food consumption, beer drinking).

Elements of acute risk and chronic risk are frequently mixed in certain patterns of behavior.:

Case Example: *Eric, a 16-year-old youngster, is attracted to an older group of teen-agers. He drinks a six-pack of beer every Friday and Saturday night and he's often on the back of a motorcycle driven by an intoxicated friend. On Mondays, Eric is either late for school or doesn't attend at all. Not only is Eric exposed to the acute risk of being injured in a motorcycle crash, he is also vulnerable to the chronic risks of truancy and of developing an alcohol consumption habit.*

Prevalence of Risk Behaviors

The high emotional, physical, social and economic costs inflicted upon adolescents, their families and society as a result of risk behaviors have prompted the Centers for Disease Control (CDC) to make the study of adolescent risk behaviors a public health priority. The CDC conducts large, school-based surveys to estimate the scope of risk behaviors. Home-based surveys are done on a less frequent basis in an attempt to obtain data from those adolescents not attending school. A satisfactory method to survey the rising number of homeless adolescents has not yet been devised.

A sampling of recent data highlights how common risk behaviors are among high school students. As measured by their anonymous self-reports,

- 33% engaged in episodic heavy drinking
- 52% used alcohol
- 39% rode with a driver who had been drinking alcohol
- 20% have carried a weapon
- 24% have seriously thought about attempting suicide
- 53% have had sexual intercourse
- 46% of sexually active students did did not use condoms during intercourse

Risk Factors

Researchers who have attempted to define how various risk behaviors cluster in individuals have demonstrated that some adverse outcomes occur more frequently in certain regional and demographic groups. Social factors such as poverty, lack of access to health care, homelessness and minority status also contribute to elevated risks for adverse outcomes. Within the family, easy access to tobacco and alcohol is a risk factor for teen substance abuse. The presence of firearms in the house is associated with an increased risk for suicide and violence. An important area of study investigates the ways in which several factors might interact to raise a youth's risk.

Risk Behaviors and Normal Development

Transient encounters with risky choices and situations are part of normal development and allow adolescents to gain mastery over situations that they will face throughout their adult lives. A limited exposure to risk is necessary for teen-agers to gain independent decision-making skills. Unfortunately no set method or age criterion exists that can determine a teen-ager's readiness to handle risky situations independently in a safe and responsible manner. A teen-ager's judgment, insight and level of preparation will affect his or her ability to face risk and avoid harm.

Risk Behaviors and Mental Illness

Certain risk behaviors that are severe or persistent might be the first indication that a teen-ager is experiencing problems stemming from a mental illness. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) lists the following behaviors as signs and symptoms of certain mental disorders:

- Not eating
- Self injury
- Self-induced vomiting
- Drug or alcohol use
- Violent acts
- Talk of suicide
- Assaultive behavior
- Weapons use
- Reckless behavior
- High risk sexual behavior

Higher rates of self-injurious behaviors, suicide attempts and eating problems occur in clinical populations of adolescents being treated for psychiatric disorders. The timely diagnosis and effective treatment of mental disorders can reduce those risk behaviors that are the symptoms of a mental disorder.

Case Example: *Jessica is a 15 year-old girl who has been sexually active with her boyfriend for the past six months. During the past two months she has experienced symptoms of depression which she has attempted to relieve by drinking wine coolers. Although she has access to appropriate health care services and ordinarily uses condoms when she engages in sexual activity, she did not use them consistently when she was drinking.*

During a visit to her pediatrician, Jessica was screened for symptoms of depression and substance abuse, and a referral was made for mental health services. During the course of treatment, it was determined that Jessica's judgment and planning abilities had been impaired by her mood disorder and her drinking. She responded well to therapy, her symptoms of depression abated, and she was able to speak about her use of substances to relieve her feelings of sadness. She stopped drinking and once again began to use condoms consistently during sexual activity. Fortunately, she did not become pregnant and did not contract a sexually transmitted disease.

In this case, professionals in the fields of pediatrics and mental health collaborated effectively to serve Jessica's unique needs.

Mental Illness and Violent Behavior

An area of ongoing public debate and frequent misunderstanding involves the relationship between mental illness and the risk of violent behavior. The most recent research in this area indicates that individuals with mental illness who have been treated and are not experiencing acute symptoms are at no higher risk to commit violent acts than the general public.

Studies have shown that drug and alcohol use have a stronger association with violent behavior than does mental illness. Violent acts are generally directed toward family members and acquaintances rather than toward strangers. Specialized studies to systematically evaluate the relationship between the symptoms of active mental illness and the risk of violence in teen-agers are needed.

Preventing and Reducing Risks

As teen-agers develop and learn to function and make choices on their own, they are less subject to adult supervision. Many of the independent choices that teen-agers face will present them with an opportunity to consider the consequences of their decisions and actions. Some of the choices they make, however, will have the potential to introduce significant elements of risk into their lives. How they fare in these situations will depend to a great extent on their previous life experiences. The specific developmental needs of teen-agers as they progress through the stages of adolescence should be considered.

Pre-teens and young adolescents (ages 11-15) are rapidly expanding their range of activity and cannot practically be under adult supervision every time they make decisions involving risk. The involvement of younger teens in school or community groups is often effective in providing them with the autonomy they desire while maintaining reliable adult supervision. After-school hours are often unsupervised and a youth's participation in a quality after-school program will reduce certain risk behaviors by providing constructive supervised activities as alternatives. In such settings adults remain available to teach the young adolescent about responsible behaviors through role modeling and discussion.

During the **middle to later teen years (ages 16 - 19)** most adolescents spend more time beyond the range of adult supervision. Young, inexperienced drivers in this age group are at increased risk for motor vehicle accidents. Parents should pay special attention to their teen-ager's driving skills and road safety habits. Opportunities for an adult to ride with a young driver should be sought and encouraged.

The role of families

A youth's sense of connectedness within the family exerts a significant protective effect. The protective factors at work in the family are the presence of parents at key times during the day, shared activities between parents and teen-agers, and high parental expectations regarding school achievement. Organized family patterns with clear rules regarding behaviors might also be protective.

Children and teen-agers at every age learn from the role models around them. If healthy habits and responsible safety practices are incorporated into the routines of daily family life, most children stand a better chance of adhering to these patterns as they mature. The experiences and lessons of the childhood years form the foundation of an adolescent's responsible and safe independent behavior. During the pre-school and school years, opportunities to teach children about health and safety practices should be sought by adults. Children at this age have a natural desire to learn about rules and

will be eager to be taught basic rules of household, traffic and water safety. A portion of the 'quality time' that parents spend with their children can be devoted to discussing relevant safety matters.

Healthy nutritional practices and balanced eating should be observed by the family. Dietary habits that will be maintained for years are instilled and consolidated during meal and snack times. Parents can help teen-agers enhance their nutritional habits by noting what healthy foods their teen will eat and making sure that they have access to that food during meal and snack time.

Peer pressure often plays a powerful role in the situations teen-agers encounter and the choices they make. In surveys teen-agers commonly report that they would not go to their parents to discuss problems that might involve experimentation with drugs, sexuality or illegal activity. Instead they frequently seek advice and direction from a peer. Studies have demonstrated that involvement with a risk-taking peer group will increase a teen's chances of participating in risk behaviors. Parents can monitor and address the influence of peers on their teens by regularly making time available to talk with their adolescents. During these talks it is generally productive to allow the teen-ager to speak about the risk behaviors they see others performing. When risk-taking is obvious, it is best to address it directly with the teen in clear terms, outlining the concrete threats to their safety and health.

The role of adults

Adults involved with teens on a regular basis have the capacity to modify the effects that peer influence and life circumstances exert on adolescents. Research has shown that involvement with at least one positive adult figure in the home, school or community can exert a protective effect on at risk adolescents. Some studies have suggested that even when adolescents do not have supportive families, risk can be lowered by an informal support network of adults comprised of teachers, neighbors or other community members.

The role of schools and teachers

Studies have shown that schools might serve as protective buffers. Active involvement in school activities can provide teen-agers with a source of solace to help them cope with adversity and to help them develop pride in their involvement in constructive activities. Teachers also serve as role models and sources of support.

Many young children are likely to encounter persons involved with drugs in their communities. Children entering school can begin to learn basic information about the importance of avoiding illegal drugs. Information about safety and healthy living is most effectively presented to young children when the teaching methods are interesting and fun.

Some preliminary outcome studies have shown that interventions geared toward adolescents in community and school settings might be effective in preventing certain risk behaviors. For example, afterschool, non-academic skill-building programs have shown some promise. However, these studies have not been replicated, and much work remains to be done to determine if specific interventions consistently reduce risk behaviors and their associated adverse outcomes. The full service schools model, in which schools serve as community centers for families, may prove to be effective.

The role of health professionals

During adolescence, an individual's health care needs change significantly. As teen-agers become more independent they often claim that the lack of confidentiality is the reason they do not seek clinical services. Often teens are unwilling to seek care at clinics established to serve younger children or adults. Health care professionals working with adolescents must take into account the teen-ager's growing developmental need for autonomy and privacy. Guidelines developed by the American Medical Association and the Centers for Disease Control and Prevention recommend periodic developmentally appropriate counseling and screening by primary care clinicians. Counseling should 1) reinforce the importance of setting clear expectations for adolescent behavior, 2) emphasize the influence of parents as role models for maintaining healthy behaviors, and 3) reduce the availability of firearms. During office visits a teen-ager should be given a private opportunity to discuss health-related matters, including a review of possible risk behaviors. Many teen-agers respond positively to the added privacy of this approach and are able to discuss topics they would not be willing to cover with a parent present. Information sharing should be emphasized during the encounter, and materials related to safety and risk reduction can be made available to teen-agers (and their parents) during office visits.

CONCLUSION

Risk behaviors are often a sign of normal adolescent exploration that can be discussed, understood and eliminated before harm occurs. Parents and clinicians must remain attuned to the possibility that a serious or persistent involvement in risk behavior might indicate that a teen-ager is experiencing a deeper problem in life. In either case, adolescents require appropriate and timely responses based on their unique developmental needs. When adults involved in the care and supervision of teenagers are able to provide such developmentally informed responses, they will improve a youth's chance to avoid harm and to enjoy a healthier and happier life.

Attention-Deficit/Hyperactivity Disorder (ADHD) Studies for Children and Adolescents

The NYU Child Study Center is conducting research for children between the ages of 6 and 15 who suffer from ADHD. Youngsters who qualify are evaluated and treated at no cost for further information please contact Janet Wetherbee at 212-263-7779

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ABOUT THE AUTHOR

Gary Gosselin, M.D., Clinical Assistant Professor of Psychiatry at the NYU School of Medicine and Chief of the Adolescent Inpatient Unit at Bellevue Hospital Center, has worked extensively with adolescents at risk and has presented at numerous professional meetings and conferences. Dr. Gosselin has a special interest in interdisciplinary approaches to the problems of adolescents at risk, particularly in the effects of the legal system on mental health services for families and children.

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child study center

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550 First Avenue New York, NY 10016 (212)263-6226

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Child Study Center
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How to Help your Teenager be Happy, Safe and Responsible

The National Longitudinal Study on Adolescent Health followed about 12,000 teens from 7th through 12th grades for survey interviews, which asked about their behavior and feelings. The study found that teens who report feeling connected to their families and school were less likely to have behavior and health problems. This research shows the huge impact that a quality parent-child and school-child relationship have on the path that adolescents choose. Here are some practical tips for parents that these finding suggest are helpful for teens and their families.

1. **Maintain a positive relationship with your teenager**
   - Allow, even encourage, choices and respect teen's growing independence. Be prepared to negotiate and compromise
   - Communicate positively and show your appreciation for the teen's role in the family. Thank and praise your teen for their efforts with chores, helping with younger siblings, trying to cheer people up, etc.
   - Be less judgmental about the "small stuff": clothes, hair, etc.
   - Guarantee time to do enjoyable things as a family; try to allow all members some say in what to do. You may like art museums, but dragging your adolescent who is vocally opposed to doing that may not be the best way to have family fun.

2. **Know your child's friends**
   - Encourage relationships with worthy peers
   - Get to know the families of your child's friends
   - Reserve expressing your negative reactions for the REAL problem kids

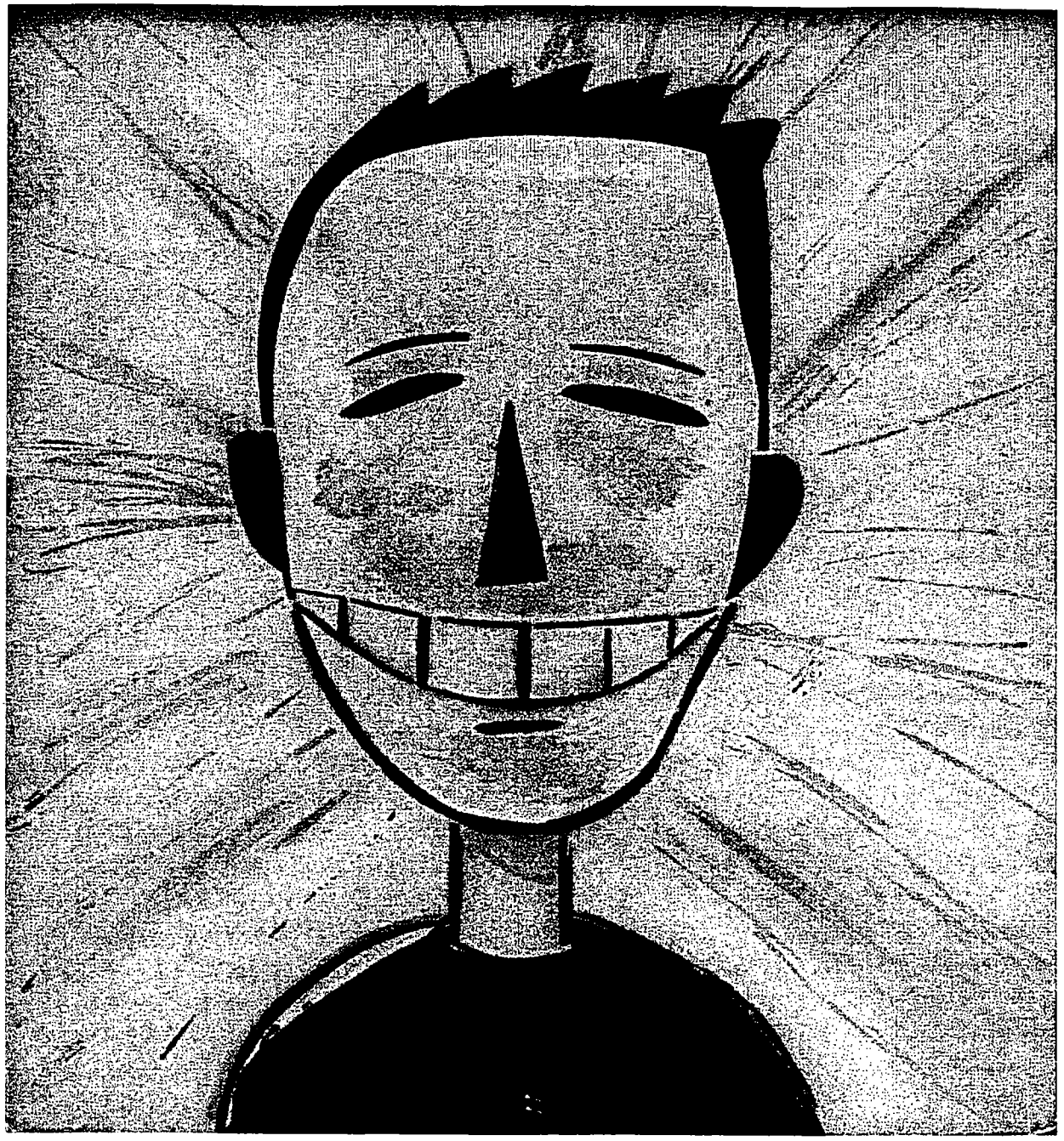
3. **Identify your child's talents and hobbies**
   - Engage your Child's talents – this will help improve self-esteen
   - Encourage hobbies – this might lead to more involvement with like-minded peers

4. **Set a good example for responsible behavior**
   - Be a good role model – Kids from homes that have ready access to cigarettes, alcohol, and drugs were much more likely to use these substances
   - Admit when you make a mistake – Adolescents have a built-in "hypocrisy detector"

5. **Don't involve adolescents in marital squabbles** – The risks of all sorts of childhood and adolescent problems increase with family disharmony and chaos.
   - Don't act out marital squabbles by trying to be your teen's buddy and "freezing" out your spouse
   - Get help soon if one parent is abusive and hurting other family members

6. **Keep the house free of dangerous objects**
   - Don't keep guns in your house – violence and suicidal thoughts and behaviors were much more likely in homes where there was easy access to guns

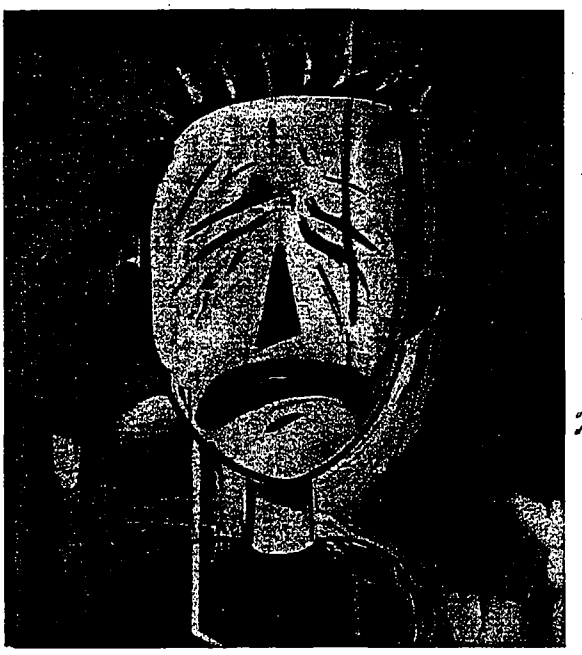
NEW YORK
NOVEMBER 24, 1997



Parents of kids who got their lives back with the help of antidepressants have little patience with those who say Prozac is being prescribed too casually to children. They've already run the guantlet of testing, tutoring, and therapy and are just thankful for relief. **By Susan Brenna**

ILLUSTRATIONS BY PETER KUPER

IT'S NOVEMBER, FALL SCHOOL-CONFERENCE TIME. SOME PARENTS WILL be launched into the holidays with nothing more alarming than a lecture on punctuality. But others will find that all the worries they've suppressed about a son's anxiety attacks or meltdowns over math, a daughter's distractedness or her outcast status, will come rocketing to the surface when a teacher says, *We think there's something wrong. We think you should take a closer look.* Soon, these kids will be in a tester's office, and their parents will be barraged with contradictory advice—to hire a tutor or a homework coach, to consult a neurologist or a language specialist or a psychiatrist, to commission a battery of tests that will reveal in exquisite detail the idiosyncratic strengths and weaknesses in their child's mental arsenal—but no obvious course of correction. And what about medication?



Earlier this year, a place called the Child Study Center opened at New York University School of Medicine under the direction of the charismatic child psychiatrist Harold S. Koplewicz. Currently in the national spotlight as the best-known advocate of treating childhood mental disorders with drugs, Koplewicz has also built a local following of families grateful for his promise to demystify the chronic mood and learning disorders of childhood. That's why the heads of many of the city's most prominent private schools have joined his board, and why, though the center is only eight months old, it's already $5.2 million toward its goal of raising $20 million.

A remarkable portion of that has been raised by, and from, parents who have trod every inch of the New York circuit, from psychologist to psychiatrist, tester to tutor, therapeutic school to boarding school, seeking the elusive perfect blend of therapy, pedagogy, and pharmacology that will give their offspring a shot at a normal childhood.

Lisa's father resisted drug therapy. "Bu t your're holding your child and she's rock i

Not surprisingly, the best New York psychiatrists are using the most advanced therapeutic and pharmacological treatments with children. Kids are taking antidepressants (among them Prozac, Zoloft, Wellbutrin, and Luvox), anti-anxiety drugs (BuSpar), and psychostimulants (including Dexedrine and Adderal). And they're being prescribed drugs in combinations to treat multiple disorders, because a child with learning or attention problems is often anxious or depressed. But for the apparently growing number of kids who have problems just getting from breakfast to *Hey Arnold!* without being hammered by their emotions, Koplewicz and his colleagues at the Child Study Center are looking beyond therapeutic breakthroughs. They're vowing to make treatment user-friendly, to offer clarity to confused, exhausted parents, and to merge the advancing science of childhood mental health with the practical realities of schooling and child-rearing.

"We want the Child Study Center to become a household word when it comes to helping parents and schools deal with children who have these challenges," says Sandra Theunick, head of school at Chapin. Joining her on the center's advisory board alongside Schools Chancellor Rudy Crew are the heads of Dalton, Horace Mann, and St. Bernard's, among other schools. "Right now," Theunick adds with some frustration, "everybody is out there on their own."

Perhaps New York kids are more vulnerable to mental distress, or their exposure to early intelligence and behavioral testing (for admission to private kindergartens or gifted classes) allows aberrations to be caught more frequently—and for parents to begin the therapy rounds before their kids can catch a ball. Maybe parents in New York are less muffled by stigma or can better afford the mental-health treatments many insurers limit or refuse to reimburse altogether. But virtually every middle-class New York mother knows a pack of kids who get tutored for learning or attention problems, who regularly visit the school psychologist or their own therapists, or who have medications dispensed by the school nurse. A prominent Upper West Side child neuropsychologist, Antoinette Lynn, estimates that as many as a third of children in some private schools use one of those aids.

There are critics who argue that the treatment trade finds its custom in overanxious baby-boom parents pursuing an impossible goal: pain-*free* lives for their children. Parents who have spent years trying to explain to a child why he can't learn what his friends are learning—or why he doesn't *have* any friends—boil over at such suggestions. If, as practitioners claim, child psychiatry trails the adult field by at least a decade, then the moralistic wrangling this summer over the phenomenon of children taking Prozac arrived way ahead of schedule. It was only four years ago that psychiatrist Peter D. Kramer wrote *Listening to Prozac,* which introduced into dinner-party debate the question of whether the antidepressant might be used as "cosmetic psychopharmacology" to touch up glum personalities.

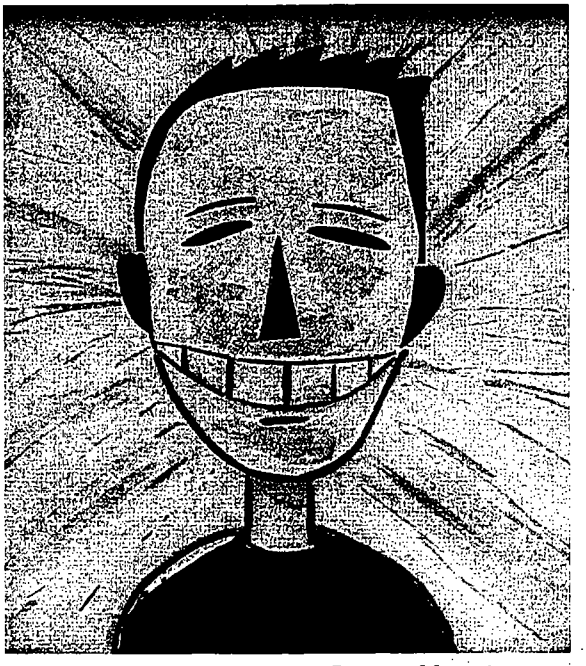
Clinicians have reason to be cautious about treating kids pharmaceutically. Children often resent taking the medication. The drugs don't always work, or they work for a while and then stop. Insurers sometimes push them not as one element of treatment but as a substitute for costly counseling. And unlike Ritalin, which has

been used and studied as a treatment for attention problems—the most common pediatric brain disorders—for more than 30 years, the newer selective serotonin-reuptake inhibitors (Prozac included) are backed more by anecdote than by scientific research.

In "The Doping of America's Kids," the New York *Post* editorialized on August 18, "If we are to accept the claims made by defenders of prescribing drugs for childhood problems, then America is now a nation of deranged youth." It added, "We wonder if kids have always been so psycho."

It seems they have not. For whatever reasons—culture, biology, chemical pollutants?—scientists report mental illness in children, particularly depression, is increasing everywhere in the world. The federal government estimates that an astonishing one in five children at some point suffer a mental-health disorder—twice the previous estimates. Researchers now believe most affected children suffer a triple whammy: genetic predisposition, environmental stress, and a chemical imbalance somewhere in the brain's major neurotransmitters. Social critics who blame the breakdown of the family on inattentive parents don't allow for that subtle interplay of culture, genes, and brain chemistry.

In some ways, the development of pharmaceutical treatments has driven diagnosis. Just as the effectiveness of the drug lithium brought manic-depressives out of hiding in the sixties, the past two decades' rapid development of drugs to ease blights such as obsessive-compulsive disorder, social phobia, and depression have brought all manner of anguished children into doctors' offices. Children have benefited from an echo effect, as adult-tested treatments are tried, usually after counseling has failed.



what do you do," her mother asks, "when back and forth saying, '*Kill* Lisa, *kill* Lisa'?"

And because drugs now exist to treat a greater variety of disorders—and because the choice of drugs to treat each disorder is expanding—clinicians are homing in on finer, more exact diagnoses of children's' complaints. "It's not just the patients—it's the diagnosticians who are coming out of the darkness" as pharmaceutical success stories become clinical lore, says research psychologist Rachel G. Klein.

BUT THE RULES OF PARENTING HAVE also changed. A good parent, in 1997, does not shruggingly accept that her child is socially shunned, or that he can't write a sentence. She investigates, and quickly. Childhood is short and full of compulsory labors, "and if you miss a year of math, you're in big trouble," says Child Study Center psychiatrist Glenn Hirsch. "If you're in third grade and you don't form friendships, you're locked out—meanwhile, everyone else is practicing social relationships."

A dentist, the father of a 4-year-old boy diagnosed with pervasive developmental disorder, notes that "there's a window of opportunity" for his son to learn. Koplewicz is treating him with an unconventional cocktail of Luvox and the stimulant Dexedrine—which focuses attention—along with behavior modification at school and home. "The drugs are not a cure," this father says, acknowledging that the problem "is not going to go away. But if I don't get to Andrew *now*, he's going to miss his life."

Parents also worry about where their socially awkward child, or one who struggles to process written information, will find a niche in a world in which the big growth fields are communication and technology, marketing and managing. Nor does a parent any longer assume that a nice but adrift screw-up will eventually slide into a career if he can hang on through twelfth grade. High-wage, low-skill labor is the dust of nostalgia, at least in New York City. Parents look at their struggling kids and wonder whether there will be a place for a brilliant boy who laughs when nothing is funny, who will never sit at a keyboard all day. "When I grew up, people lived in much larger, extended families, and there were aunts and uncles and cousins and everyone was different," says the Chapin School's Theunick. "Some were brighter, some were less so, but everybody was accepted, everybody knew they would be taken care of in the world, everybody would have a job." No longer. "So we find ourselves working with parents and children in a dynamic that"—she stops and hunts for a word—"that's pretty *impatient*, in terms of taking the time that's necessary in helping children get to their best level."

In August, President Clinton, prompted by reports of a two-year, 80 percent increase in the number of pediatric Prozac prescriptions, called for more rigorous testing of adult-approved drugs being prescribed "off label" to children. Research scientists have complained for years that even commonly prescribed antibiotics and asthma medications, much less psychotropic drugs, have never been approved by the FDA for children.

Around the time the president weighed in, I ran into an acquaintance in a Manhattan park where our children were playing. I remembered that when we'd spoken a couple of years earlier, she was struggling to concoct meals that her then-6-year-old, Lisa, would eat. Lisa's pediatrician had banned any number of natural and processed foods, on the theory that allergies to many of her favorites, like apples and tomatoes, were causing her disruptive school behavior.

As this mother brought me up to date—describing the now daily grind of Lisa's attention problems, how she never knew whether her daughter would hug her or punch her, and how her husband had resisted a trial of psychostimulants—I knew where the conversation was heading. Her voice began to tremble. "But what do you do," she said, "when you're holding your child and she's rocking back and forth saying, '*Kill* Lisa, *kill* Lisa'?" I looked across the grass to where the kids were riding their bikes. The woman swiped her eyes with her shirtsleeve.

As the chief of research for child and adolescent disorders at the National Institutes for Mental Health, Peter S. Jensen has warned that chemically "recalibrating the thermostat" in developing brains could permanently alter neurotransmitter function. But while those effects are unknown, Jensen points out, the effects of *not* treating are known, and devastating.

SANDY MARSDEN BECAME ONE OF THE FIRST donors to back the establishment of the Child Study Center after following a typically winding trail. Her older son, Peter (their names have been changed), had tremendous difficulty sitting still in first grade at his boys' school, but she didn't grow seriously concerned until third grade. She had him tested by a psychologist, got an inconclusive diagnosis, and spent a year with Peter making no progress in traditional counseling. Some time later, she ran into Koplewicz, whom she'd met socially, on the street.

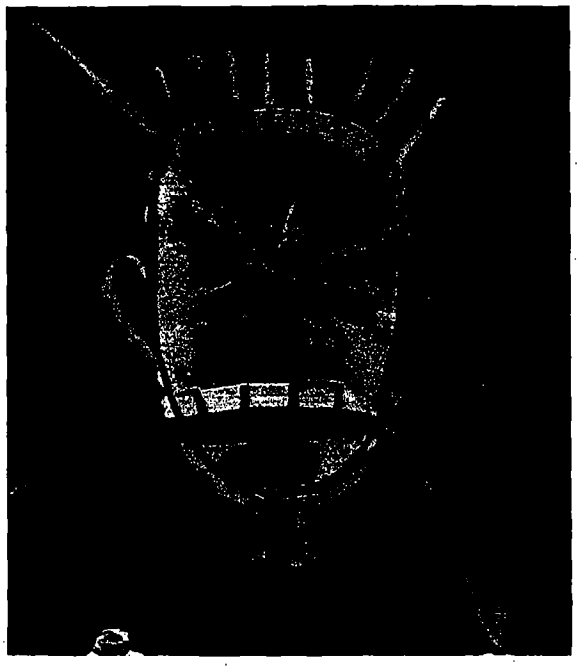
Marsden decided right there to have him look at Peter's tests. Koplewicz phoned her and asked whether anyone had ever mentioned that Peter had a classic attention deficit. Now age 16, he has gone on and off various medications, a common process, and is thriving at his New England prep school. But because the nurse who dispenses the pills is a long crack-of-dawn walk from his dorm, he doesn't always take his Adderal.

Marsden's very verbal second son, Matthew, so charmed his teachers that no one realized how little he was actually learning until third grade. He, too, fooled around with tutors and fuzzy evaluations before Marsden finally sent his test records to Koplewicz, who was then practicing on Long Island. Now 13, Matthew, too, is doing well while taking Ritalin for ADD and the antidepressant Wellbutrin.

Neither of these stories approaches tragedy—no one asked to die, although Marsden will forever remember Peter telling her, after a disastrous family trip, "I don't *want* to be so bad." Moreover, if you accept even the conservative estimates that 10 percent of children experience mental disorders at some point, and that only half are ever treated (advocates estimate a third), that leaves 80,000 New York kids who will suffer without treatment, many because their families can't afford it.

Brooke Neidich, chairman of the Child Study Center's board, said in a weary tone, "I don't think I can bear another story asking if kids are overmedicated. I don't think this will ever be settled. I don't think people are at ease when *adults* take Prozac."

She supports the board in part because it was such a struggle for her to find answers to some of the problems of her own children. "I kept thinking, This is so



"A third of the children who see me," says the Child Study Center's Harold Koplewicz, "*don't* get medicated."

absurd. We have all the advantages. We're educated; my husband and I are very supportive of each other; we have a great marriage. Why is this so complicated for us?"

Koplewicz argues that a hospital-based program that combines research, practice, and education, and that gathers all the therapeutic disciplines under one roof, has the best shot at providing parents with clarity. He argues, "Most parents, when they are faced with news from a school or from other parents that someone thinks there's something mentally wrong with their child," react by feeling "either defensive or guilty. But most of them feel overwhelmed."

Then the parents' struggle to integrate what goes on at home, in school, and in sessions with the psychologist, Koplewicz says, is even more overwhelming. Medicine alone is never enough to turn around a child's life. He'll almost certainly need to learn new ways to cope with school and his social relationships, and his parents will need coaching in how to help him. That's one reason the center's goal is to begin standardizing guidelines for the most effective approaches at home, in school, and with the doctor.

"Say there is an 8-year-old girl who can't speak, who's so uncomfortable in class that her teacher is getting annoyed, who's socially rejected, who's starting to tell her parents she doesn't want to go to school," Koplewicz says, sketching some details. "At home, you would talk to the parents about social rehearsal, how they would sit with their child and say, Let's make a conversation, let's practice 'you' questions because people like to talk about themselves—'Where did you get that sweater?' If she's going to a birthday party, they can visualize with her what it would be like, ask if there's something she can bring to make her feel calmer.

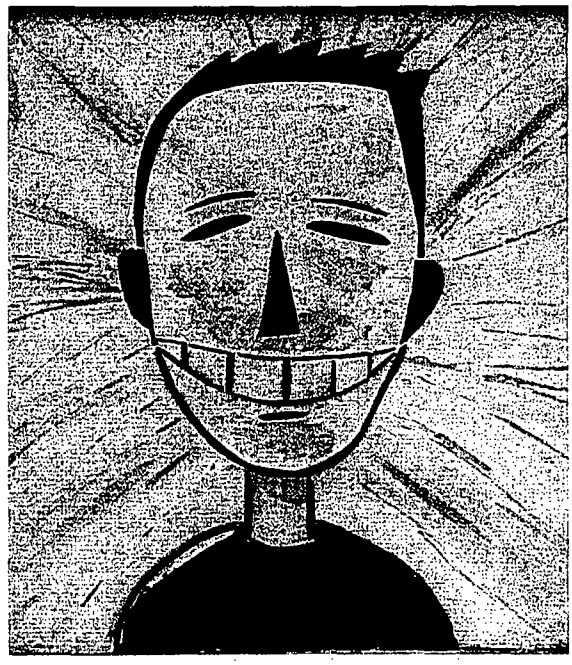
"At school, we can try to help the teacher understand that she's not defiant or oppositional. We can discuss if there's a way she can speak in smaller groups, maybe not in front of the whole class, or if she can go first or second so she doesn't have that anticipatory fear.

"As for medication, we would try all the psychosocial interventions first. But if it's needed, we might try very low doses of an SSRI, most likely Prozac or Luvox, Luvox because it's been approved by the FDA for kids under 12 with obsessive-compulsive disorder, so at least we know it's approved for another type of anxiety."

The notion of standardizing treatments alarms some practitioners. "There is no cookbook for these disorders," East Side pediatric psychopharmacologist Peter Kaplan says. On the other hand, "a school can receive a ten-page evaluation of a child," Theunick says, describing how a situation might go at her all-girls private school, "and the parent gets it and the learning specialist gets it, and now we know what one particular practitioner thinks about your child's brain or func-

tioning. And there may be in that child's file an earlier evaluation by another practitioner that makes an entirely different set of recommendations." Although virtually all private (and some public) schools employ psychologists and learning specialists, she says, "we need a way of working with that material that's better than we currently have—a format, a protocol, a vehicle for making sense of it, a place to consult. We need something so the adults can work better as a team."

EDUCATORS ARE DIVIDED ON THE question of whether teachers have grown more sophisticated at spotting potential learning or emotional problems, or whether schools—public and private—simply have narrowed the definitions of acceptable behavior and achievement. "I think there has been some narrowing, and I think it has to do with how teachers are trained," says James Simone, associate superintendent of special education for the Archdiocese of New York, who has invited staff of the Child Study Center to train Catholic-school teachers in mental-health screening. He believes most teachers know too little about the variability of child development, but also that they "fear failure" with their students and sometimes rush them toward evaluations. And parents may also panic. Some, psychologists say, can't accept that their children don't meet their high standards for social or academic success, and they're seeking a medical explanation.



But even when parents and schools are well-meaning, the negotiations can be charged. And it's one of the reasons psychologist Gail Furman and her husband, real-estate developer Jay Furman, made the first seven-figure contribution to the Child Study Center. Furman put in a combined 23 years as a psychologist, first at Fieldston and then at Dalton, and now practices independently. She criticizes the insularity of schools referring parents to the same small cadre of private testers—usually psychologists—and then relying exclusively on their recommendations for treatment, even when parents strongly disagree. "There's this little cabal and no accountability," Furman says. "What I have seen in many years of practice is that all too often there is not a good integration of all the players in a child's life—the parents, the practitioners, and the school."

Furman describes one recent situation in which she was called by a city official to intervene in a poisonous battle. The parents had complied when their 4-year-old daughter's top-flight school had referred her for an evaluation, but opposed the recommended thrice-weekly language tutoring and Ritalin. "The parents had a lot of questions about rushing the intervention quite so dramatically for a 4-year-old," Furman says. She felt the girl's problems might ease with another year or two of development; nonetheless, she observed and "helped out" in the child's classroom for several months. "What I spent a lot of time doing was not working with the child but working with the school to get them to give me a little latitude with this child," she says.

There are many kinds of evaluations. Those that cast the widest net can last nine or ten hours and test a child's intelligence, cognitive and motor skills, verbal and visual memory, personality traits, expressiveness, and mood.

Antoinette Lynn notes that a school that may be preparing to "counsel out" a child can't ethically wait beyond November to blow the warning whistle. Parents need time to find a psychologist and schedule the testing, a process that can take two months (and cost between $1,000 and $3,000). Then "remediation" must have a chance to work before a final decision is made. "Either the school has to hold on to that child for the next year," Lynn says, "or else they have to build in from the beginning of the process the idea that this is not the right school for the child."

Educators argue that schools rarely boot a child after only a few months of therapeutic trial-and-error—most psychologists believe the process should be given a minimum of two school years—but it happens. "I've seen evaluations used that way. Some schools are excellent in dealing with families, and some are horrible," says Kaplan. "If anything, I've seen schools hang on too long to kids who need total immersion in a school that will do intense remediation," says Judith Hochman, head of the Windward School for children with learning disabilities. Still, the accounts of such catastrophes circulate widely enough to keep families in a state of permanent alert.

"The medication changes my personality," says Aaron. "I don't know if that's good, but I'm happy with life now."

AARON KING, A COLLEGE SOPHOMORE, was almost certainly unaware of how closely he was echoing some of the themes of *Listening to Prozac* as he discussed how radically different he'd felt since he'd begun taking Zoloft at age 14. At the time, he was suffering from such severe panic that he spent most days bent over with stomach cramps. Aaron (not his real name) remembers gripping the edges of his desk, sweating and flushed, dreading the moment he'd be called on to speak. He'd strain to croak out an answer, and his classmates would gawk.

He could calm himself by crying behind his closed bedroom door at home, but he couldn't cry in middle school, so while everyone else was changing classes he'd flee to the boys' bathroom and perform a ritual. He'd pull out his penknife, open the blade and rest it on his wrist, just looking at it. "I thought about killing myself all day long," he says now, "but I couldn't do it, I guess because of my background or whatever. I kept thinking about my parents. They didn't do anything wrong."

He began to see Dr. Kaplan after he had a breakdown on a school trip. He has taken Zoloft for almost five years and has learned to live with contradictory messages. His mother, he says, is content to have him stay on the medication as long as he is happy and functioning, while his father, a physician, is less certain. Aaron is ambivalent. "I feel like I'm a totally outgoing person now," he says. "I couldn't live with the world before I was on medication, but now it's almost like I have to show off that I can speak in class, that I can have fun, that I can go out with girlfriends. I come from a very shy, reserved family, and now I have this almost cocky confidence. I really think the medication changes my personality—which, I don't know if that's all good, if it's not who I really am. But I'm happy with life now. I made the dean's list first and second semester of freshman year; I'm managing the basketball team. Everything's coming together in my life."

Is Aaron-on-medication really Aaron, or is he the quintessential souped-up kid? Or, as practitioners including Koplewicz would argue, is he the real Aaron with the mask of mental disorder pulled away?

Few would argue against treating suicidal kids with therapy—and drugs, if therapy fails. Doctors and parents have a harder time judging how aggressively to treat kids who have some but not all symptoms of a disorder, who aren't keeping up with the pack, who straddle a line between lingering sadness and depression. Psychologists are on guard against parents who try to commission proactive $2,000 evaluations of their children—just in case there might be a mental weakness—and against educators who view drugs as classroom-management tools. "Like any other individuals, children have the right to be free of pain and suffering," says Rachel Klein. She suggests, sensibly, listening to the child. "They can tell you how they feel. Some individuals can tolerate a good deal more pain than others."

Bruce Waslick, a psychiatrist with the Ruane Center at the New York State Psychiatric Institute in Washington Heights, says, "Once you get outside of attention-deficit/hyperactivity disorders, the knowledge base gets a lot smaller. We know mood disorders exist in children. But the parameters of their treatment are not well established." Where a disorder trails off into normalcy, many doctors concede, is often not clear.

At the institute, Waslick and colleagues are pursuing numerous studies on the effectiveness of psychopharmaceuticals with children. Pharmaceuticals manufacturers also are funding controlled studies. The reason most of those companies have not sought FDA approval for pediatric application of many medicines is that the required testing is so rigorous and expensive, speculates Dr. Hugh Johnston, head of the University of Wisconsin's Child Psychopharmacology Information Services. "The documentation needs to be delivered to the FDA in a small truck," he says.

"It doesn't serve the public well to regulate to the point that nobody bothers to test the compounds in children," Johnston adds, noting proposed new testing regulations on the public agenda. "But if the testing is not rigorous enough, there's still potential danger" for developing children.

Before parents even consider medication, Koplewicz says, the practitioner needs to explain, "first of all, what happens if you do nothing. Parents have to be told what is our best guess if you choose not to make any intervention. No. 2, what are your realistic treatment options," with and without medication. The first question most parents ask is whether a child will have to take medication forever. Koplewicz says it should be made clear how long a drug trial will last, and whether a child's particular disorder is one that may need only a few months' treatment. "You need to describe: What are the side effects, and what are the specific outcomes we're looking for?"

"A third of the children who see me don't get medication," Koplewicz asserts, while Kaplan says he treats half his referrals nonmedically. Sometimes medication is just a short-term aid, "to relieve the burden of the symptoms," says West Side psychologist Barbara Wolf-Dorlester, "so that therapy can be effective." And medicine without some behavioral work, at least in the early stages of treatment, is all but verboten among top practitioners.

Kaplan, who describes himself as conservative in prescribing medication, has a method from which he never deviates. "I always tell parents we'll start with a trial of medication—let's try a very low dose and see how the youngster does. Usually, it's a tiny, sub-therapeutic dose, so we can watch to make sure there will be no allergic reactions. And I always start on a Saturday or a Sunday, so the parents can watch. I trust them to report to me more than I trust schools to report."

This is the beginning of a process that will draw on many observers. Often, there will be numerous attempts before a psychiatrist achieves what he considers the most effective dosage. A practitioner may try one medication, then discard it and try another drug from the same family but with a slightly different "personality." A psychiatrist may prescribe one drug for treatment and another to control its side effects. A drug's safety is monitored by regular physical examinations of the child, and its effectiveness is systematically tracked through reports from child, parent, and teacher. The good doctors are always alert to changes in a child. Parents like Andrea Geller, the mother of a high-school junior, Max, say families should learn to live with uncertainty and, most of all, with change.

SINCE GELLER (HER NAME HAS BEEN changed) first had Max tested as a preschooler, she says, "I don't think I've had a day when I felt all was right with the world." Her son, who has an attention deficit and a mild form of depression called dysthymia, has been through five schools and three psychiatrists. At age 4, he was getting tutored three days a week to be accepted at the British-style boys' school his brother attended. At age 8, he was overweight, lethargic, and friendless. "He would tell me that nobody liked him," says Geller. "The kids who have it together shy away from kids like him." He moved to a less pressured co-ed school that offered him special tutoring—at double the regular tuition. He went for two years to a school for children with learning disabilities (tuition: $27,800) before being mainstreamed back into his old prep school, drastically behind his classmates.

Max fell in with kids "that I would cross the street to avoid," his mother says. He and a sleepover friend snuck out of the apartment one midnight while Geller slept and were picked up for spray-painting a Madison Avenue store. "I was so smug. I really thought I'd caught all his problems early," she says.

The year Max turned 9, he and his mother were wrestling with homework. Max turned to her and said, "Mommy, if everything is going to be this hard, I don't want to go on." Only then did she consider medication.

BUT NOW SHE IS ALMOST SANGUINE. MAX, who attends a therapeutic boarding school, is confident and even happy spending most of his free time teaching rock climbing. This summer, he pumped gas and made about $40 a day in tips. "I don't know about you," she says, "but I've never tipped a gas-station attendant in my life. I couldn't care less at this point if he ever attends college. He's got an entrepreneurial spirit like you wouldn't believe."

She can no longer manage his medication. He takes his Wellbutrin regularly, but he has taken himself off Ritalin. She must have faith that he can make those decisions wisely, because he is 16—almost an adult.

"When he started, I never asked if his medication was FDA-approved," Geller says now. "I just know that when he took it he became a different kid. It's like anything else in medicine. I guess you have to take a leap of faith." ■

T&C's Guide to Good Parenting

TEACH YOUR TEENAGER WELL

Ad•o•les´•cence: An age of both promise and peril, during which parent and child may lose their bearings (if not their marbles). In honor of this rite of passage, *T&C* offers a handbook on how best to help a teenager come into his own.

BY DIANE GUERNSEY

"I'm worried about our son," the philanthropist's wife confided to well-known child psychiatrist Dr. Harold S. Koplewicz, her companion at a fundraising breakfast last fall. "He's about to go to an Ivy League school. How can we give him the ambition to work hard, when he knows we have enough money to make it possible that he'd never have to work a day in his life?"

Dr. Koplewicz smiled, perhaps having anticipated only genial chat punctuated by more serious discussion of New York University's new state-of-the-art Child Study Center, slated to open this month under his direction. "Fortunately, it's not that common a problem," he said. Swiftly scanning their table, she retorted, "Every parent here is worried about the very same thing!"

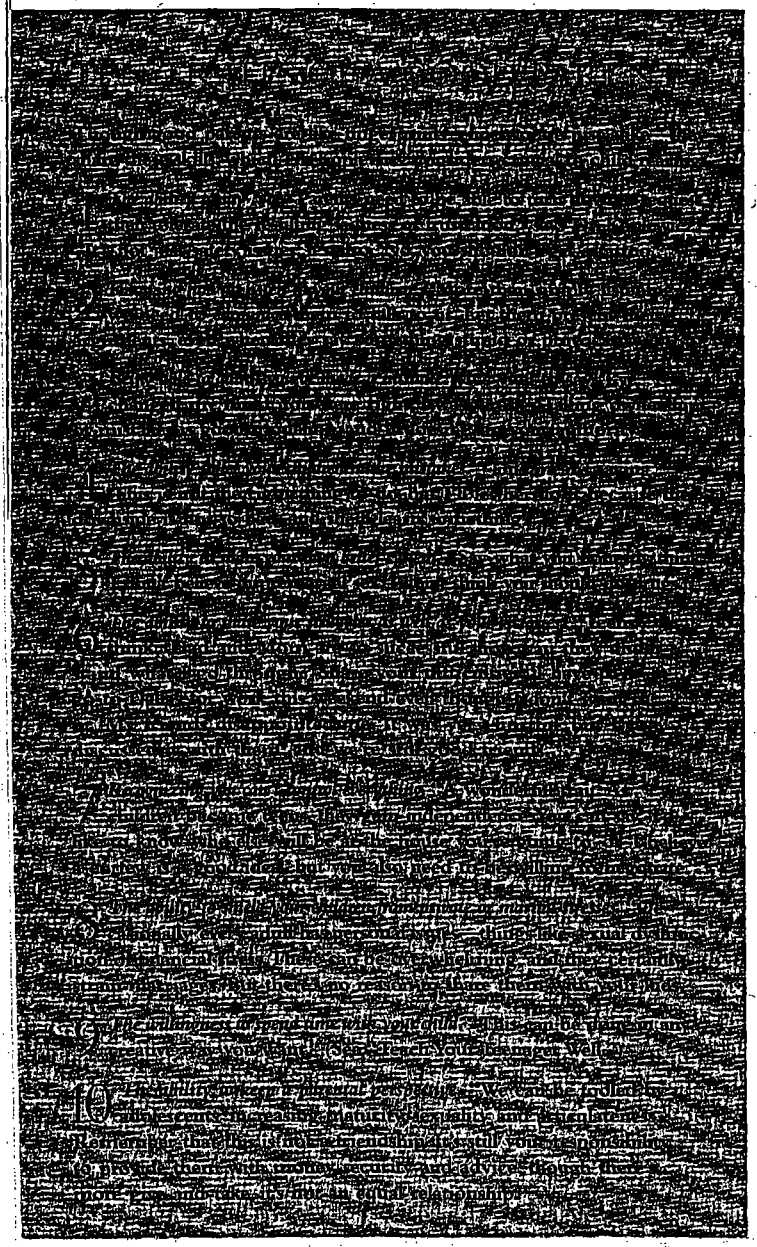
Her words cut to the heart of the affluent parent's dilemma. All mothers and fathers know how easily highflying hope can plummet into free-falling anxiety. Well-to-do parents must grapple with an additional irony: the very good fortune that lends their hopes wings also inspires their deepest fears. And as their children embark on adolescence—that long, questing journey toward adulthood—the paradox only deepens. Wishing their offspring to attain not just worldly success but success as *people*—hardworking, loving and capable—affluent parents sometimes wonder, as did the philanthropist's wife, whether their superabundant circumstances will tip the balance for good or ill. Will their children achieve a meaningful direction in life? Express their talents fully? Learn to approach relationships and money matters with clarity and common sense? Avoid overmaterialism and obsession with appearances? Use their freedom creatively, not squandering it on drinking, drug use or reckless sexual adventures? And, given their growing independence, how much (or little) should a parent intervene in their lives?

ILLUSTRATIONS BY KATHY OSBORN EDITED BY DIANE GUERNSEY

If adolescence is a journey, so too is parenting—one in which you match your child step for step, even as your paths slowly diverge. In navigating the quandaries and quagmires along the way, your native instincts are doubtless your first and best guide, but at strategic moments, you may also gain direction from the following touchstones.

Enjoy Your Teenager

Though this is the alpha and omega of parenting, it's not always simple, especially for the overbooked and ultraconscientious. "Too many parents approach kids as jobs," says Eileen Mullady, Ph.D., who heads up Horace Mann School in Riverdale, New York, and whose four sons range from a seventh grader to a Yale sophomore. "They treat parenting like going into a meeting: 'What's my agenda?' It's more helpful to approach your kids as if they were someone else's kids, with the same pleasure." What of those fleeting moments when, out of fatigue, exasperation or despair, you wish they actually *were* someone else's children? Remind yourself that this too shall pass. If it doesn't, you need to stop and examine what's going on within you, your child or your relationship.



Only Connect

Watching as your teenager navigates a gauntlet of choices about academics, friendships and extracurricular activities—from the relatively civilized (varsity sports) to the outright hazardous (alcohol, drugs, sex)—your first impulse may be to limit the risks by tightening the leash. But as teens move beyond direct control, you are far better off focusing on your emotional bond with them, which is in fact your most powerful parenting tool.

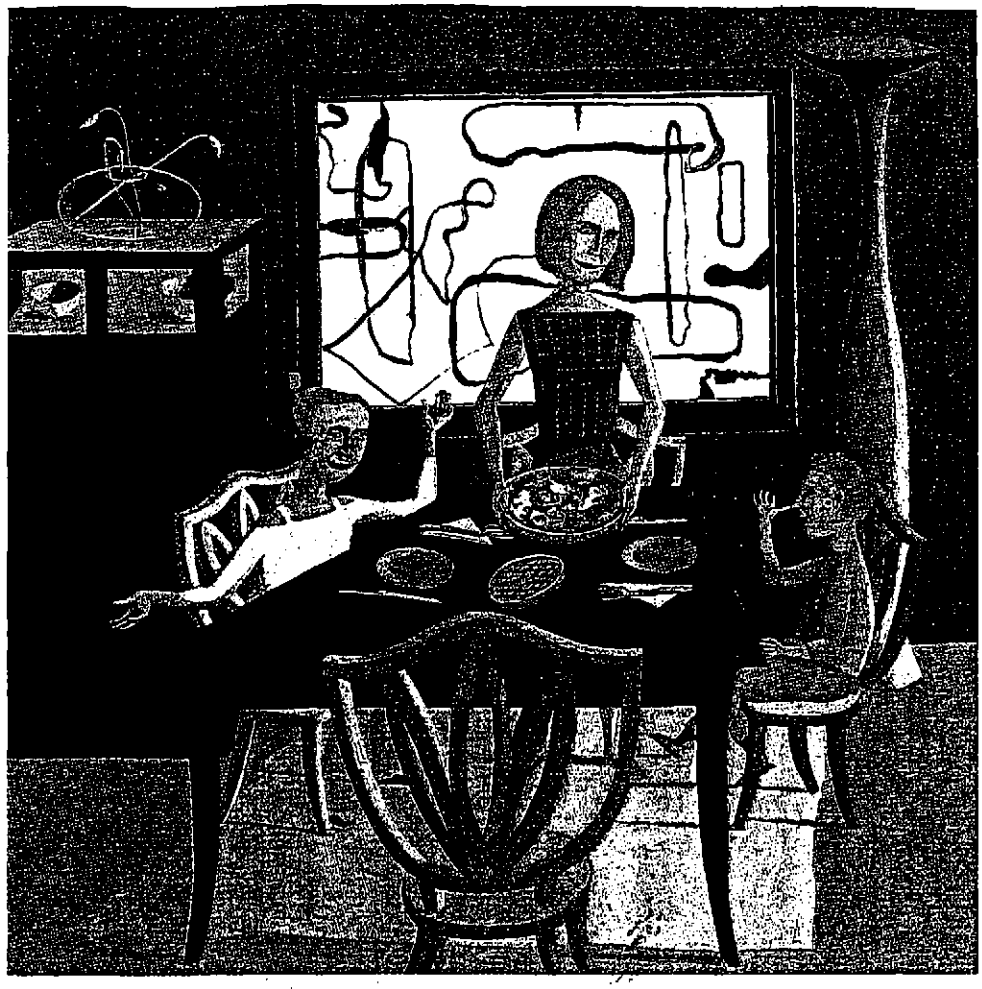
The cliché that teens rate their peers' approval over their parents' is no truer than most clichés. A large-scale study published in the *Journal of the American Medical Association* showed, for instance, that strong family bonds outweigh all other factors in helping teens abstain from drugs, alcohol, smoking and premarital sex. (Other forces for good: high academic expectations and a parental presence during after-school hours.)

In truth, the teen years may be your best chance ever to make a difference with your child. "Adolescence is when we develop the sense of ourselves that will last a lifetime," says family psychotherapist Mira Kirshenbaum, clinical director of the Chestnut Hill Institute in Cambridge, Massachusetts, and coauthor of the award-winning 1991 book *Parent/Teen Breakthrough: The Relationship Approach* (Plume/Penguin). "It's more important to make a teenager experience himself as smart, attractive and decent than to make a preschooler feel that way; and a teenager is at much greater risk of not feeling that way. Every ounce of parental wisdom, every bit of positive reinforcement, will make a quantum difference in how well your kids function and feel as adults."

Time Is of the Essence

Dr. Koplewicz will never forget his 45th birthday, thanks to a toast delivered by his 14-year-old son Josh: "Dad, do less." "Affluent parents are always pushing the envelope," admits Dr. Koplewicz. "Finding a happy balance between being accomplished and spending time with your children is quite a trick. But if you're neglectful, your kids are going to gravitate to other people, most often other neglected kids—or to substances."

To make enough time with your children, says Mira Kirshenbaum, you have to surmount the three main obstacles. "First is a demanding job. To deal with this, obviously, you've got to assess your situation—talk to your partners or boss—and make decisions. Second is overscheduling. Our schedules fill with junk just as easily as our closets. Third is that you haven't seriously made spending time with your kid a priority. You've got to arrange things so that once a week you can zero in like a laser and spend



a chunk of time with him or her alone. If your kid is away at school, try a long phone call once a week—one solid half-hour of really talking."

As for quality time, everyone agrees: it comes easier when there's quantity too. "Your time together doesn't *have* to be special," says Dr. Koplewicz. "It could be helping your kid straighten up his room, putting out the porch furniture at your weekend home, buying lunch at the gourmet shop, racing to the movie theater to pick up tickets ahead of time." He recommends scheduling family time as you would any other commitment, especially with teens, who have their own Filofaxes to contend with. Other tips: make family vacations teen-friendly (see "Teen Spirit," page 110). Have at least one "be there or else" family meal daily. Bag extra time by inviting your kids' friends over. "We encourage our daughters to bring friends here for dinner or to the movies," says Joanne Horning, founder of the Susan G. Komen Breast Cancer Foundation's San Francisco chapter. Joanne and her husband Richard, a high-octane Silicon Valley attorney, keep a tight rein on their own calendars. "Friday through Sunday, we do not attend fundraisers," she says firmly. Finally, as subversive as it may seem in these high-tech times, think twice before granting teens their own private TVs or telephones. The more time family members spend glued to separate screens or chatting on separate lines, the less time they spend together.

TOUCHSTONE NUMBER FOUR

Let Them Make Their Own Mistakes—And Score Their Own Victories

Like any fledgling, a teenager suffers some crash landings—and a wise parent will assess the damage before rushing to the rescue. "Parents can't stand for their kids to feel pain or disappointment for more than twenty-four hours," says Eileen Mullady. "But you have to let kids feel the long-term consequences of their actions. If your kid goofs off and doesn't make the team, it's best to sympathize—not to say, 'You're better than all of them!' and try to change things."

This particularly applies to school projects and job searches. "It's important that children land jobs on their own, at least the first time," stresses John Levy, an inherited-wealth consultant in Mill Valley, California. "There's something quite exciting for a young person about getting that first paycheck—especially for inheritors, who often feel dependent on their inheritance. They need to experience making it on their own." When in doubt, remember Mira Kirshenbaum's maxim: "God helps them who help themselves. If it's good enough for God, it should be good enough for parents."

TOUCHSTONE NUMBER FIVE

Don't Tell Them, *Show* Them

. . . How to Find Their Way in the World

In helping teenagers chart a course, example beats advice every time. Highly accomplished parents may chafe at this, believing that their own valuable know-how and real-life clout could nudge a teenager away from fecklessness and onto a promising path. Proceed with care, cautions Kirshenbaum. "Don't think your kid has no direction when she simply doesn't have the direction *you* want her to have. And don't let her fall for the myth that everyone is filled with direction. In reality, most people make choices with doubt and second thoughts. One of the wisest things I ever heard a parent tell a kid was, 'If you know what you want to do, do that. If you don't know what you want to do, help people.'"

. . . How to Work Hard

You can help stoke your teen's ambition by conveying the agonies and ecstasies of your own career. "It's easy to say you won an award, but most parents don't share how hard their work can be," says Dr. Koplewicz. And be sure to include the meat-and-potatoes

satisfactions. "Often I come home and say, 'I really feel blessed, because today I saw this kid and had the knowledge to give the right diagnosis to his parents, and that's going to help them.'"

. . . How to Live Your Beliefs

With personal values, it hardly needs saying: parental actions speak loudest. As Dr. Koplewicz told the philanthropist's wife, who is a generous contributor to Lincoln Center and the NYU Medical Center, "You obviously feel passionately about the arts and about medicine, and your husband is passionate about making money. You're showing your son some wonderful ways of being dedicated and channeling his energies."

Robin Hubbard, founder of New York's highly regarded ReadNet Foundation, whose computer programs help teach children to read, agrees. "If you want them to do something, *you've* got to do it." Hubbard, the mother of a 14-year-old son and two daughters, 10 and 4, admits the potential difficulty of instilling social obligation in privileged teens. "We make such efforts to protect our kids from the horrors of crime and homelessness on the streets and smut on the Internet; but then there's a danger that they won't be aware of the realities," she says. Actively involving yourself in community service helps activate your teen, too.

. . . How to Develop a Meaningful Social Life

Parents must help teens learn to mix easily with people from different social milieus. "It's all too comfortable to limit friendships to those with whom you have a lot in common," comments John Levy. "You may fear others will resent your wealth or try to get it. They might—but it's a risk worth taking. Life is a real waste if you don't go out beyond your country club."

. . . How to Meet a Challenge

At times, a parent needs to show how to engage in a heroic, no-holds-barred battle against adversity. Since 1990, Robin Hubbard has devoted enormous time and energy to helping her son Will deal with a learning disability diagnosed when he was 6. An architect who terms herself "a typical very invested mother," Robin has plumbed psychological theories of learning to help Will (along the way, she created the ReadNet Foundation), and for years worked with him daily—"with Christmas Day the only exception." All this, and persuading Will's school to meet his needs, has led to triumph, not only in Will's impressive academic record but in his self-esteem. "Last spring he made a speech at a ReadNet literary luncheon. Afterward he said, 'I think it was pretty great, don't you?'" she says fondly. "You could see and feel his self-confidence."

My Girl

BY PATRICIA MCCORMICK

The job of raising a daughter has changed dramatically in the past quarter century, but not, perhaps, as much as we sometimes think. Though girls now need assertiveness, they still need compassion. They are expected to be confident yet respectful, free from the tyranny

The entire basketball season is on the line as my 14-year-old daughter steps to the foul line. I can hardly watch. And yet I am transfixed—not just by the drama of this do-or-die game, but by the poise Meaghan shows at this high-pressure moment. I think, not for the first time, *Who is this kid?*

Like most women of the pre-Title IX era, I never played organized sports. So I can only admire, if not comprehend, the skills, physicality and sportsmanship Meaghan brings to athletic competition. And it is at moments like these that I love her most. That's because, while I delight in the ways we are similar, I *love* the ways we are different.

Back in 1970, I was a typical 14-year-old girl—overly concerned with my appearance, marginally interested in academics and only vaguely aware of anything weightier than my plans for Saturday night. I was perpetually at war with myself—eager to please the whole world, confused and resentful when the world didn't return the favor. I was quick to judge and slow to forgive.

Meaghan, a long-legged, blue-eyed blonde, is blessedly unconcerned about her looks. She has a healthy, if not burning, interest in academics and is acutely conscious of the world around her. She aims to please—but not indiscriminately. And when someone does her wrong, she is slow to judge and quick to forgive.

In short, Meaghan seems to have adopted both the timeless values I cherish and those I've been intent on instilling in her precisely because of changing times.

(Adversity, whether for parent or child, comes in too many guises to do it justice in these pages. For some of its commoner forms, see "Surviving the Successful Parent" and "The Troubled Teen"; the latter, it is hoped, will receive in-depth coverage at a future date.)

HERE BE DRAGONS

Faced with the triple threat of money, sex and drugs, most parents rely on a mixture of gut instinct and expert guidance. (A lucky amulet or two doesn't hurt, either.)

Money: The Paradox of Plenty

To a privileged teen, money may seem as ever-present and unremarkable as air. But money is, in fact, a crucible in which identity and values are forged. Affluent parents must help their children come to terms with the role of wealth in their lives, says John Levy. "They need to avoid two polar errors: pride—thinking they're especially loved by God; and shame or guilt. A good attitude is, 'Money is both a blessing and a responsibility. I have to use it as wisely as I can.'" With diligence, this feet-on-the-ground ethic can be planted deeply enough to weather the severest tests.

Take the teenage social whirl. "Too much money, too much freedom, and everybody in cars," sighs Beverly Hills psychologist Lee Hausner, Ph.D., author of *Children of Paradise: Successful Parenting for Prosperous Families* (Jeremy P. Tarcher, 1990). "What with debutante parties and the Bar Mitzvah circuit, your kids can go every week for two years to a major hotel function with an open bar and wine on all the tables. It really skews their expectations." She recalls her son's Bar Mitzvah: "We didn't high-key it. Our good friends were respectful, but the Beverly Hills kids acted like animals! For them, it wasn't special; they were jaded. Some restaurants make parents hire security because of kids like those."

How to inoculate your teenager against the horrors of "affluenza"? Starting early, advises John Levy, teach this golden rule: You don't get everything you want. "If a kid graduates from high school and wants a BMW right now, you say no. What you don't say is that you can't afford it. Talk about why you don't think it is a good idea. It's terribly important to be honest about it."

Along with loftier values, you must foster your child's skills at hands-on money management (see "Dollars and Sense," page 106). Most parents favor giving teens an allowance with no chores attached. Others, such as Joanne Horning, link payments to domestic duties. "We have help in our house, but Victoria, to get her allowance, has to make her bed. I don't let the maid do it for her."

of looks but not exactly heedless of them, either. And though we parents try to pass on values that will last, we see those values tested, stretched and, finally, redefined on an almost daily basis.

I am thrilled that Meaghan appreciates her body for what it can achieve—not for how it looks. Her unconcern over appearances is part of her charm. Her wish to go to a Broadway show in ripped jeans, however, is another matter. ("It's dark; no one will notice," she'll say. "*I'll* notice," I say.)

I am gratified that her academic interest is driven by her own curiosity and not by a people-pleasing need to get straight A's. Her belief that team sports, pop culture and E-mail are all integral to her development is hard to dispute. Her willingness to turn in an imaginative paper blemished with grammatical errors is a different story. ("What matters is what we say, not how we say it," she'll say. "People won't understand what you say if you don't say it properly," I'll say.)

And I am in deeply impressed that Meaghan has the generosity of spirit to respect others' beliefs when they conflict with hers. That she can see injustice or hypocrisy for what they are, but not need to rage against them, is astonishing. And that she is so accepting of the flaws of others is profoundly moving to me—especially when I am the one who needs, but doesn't always deserve, that compassion. ("I didn't realize you were upset," I'll say. "It's OK, you had a lot on your mind," she'll say.) It is at moments like these, when I see my daughter practice better than I preach, that I understand that she has already developed a set of values uniquely her own.

Lately, when Meaghan and I are stubbornly stuck in a debate about curfews, homework or R-rated movies, she'll summon up the two inches she's got on me and stare down her pug nose at me in mock fury. (I think this is something she learned in basketball.) We laugh, and the tension melts away. Then we usually compromise—reaching an agreement that honors my old-fashioned values and makes room for her more modern ones. I've come to realize that when I let her exercise her newfound values, I'm not backing down. I'm looking up.

What kind of daughter do I hope to raise? The kind who knows how to balance the time-honored values my parents taught me with the more forward-looking ones I've adopted as a parent, and those she has distilled from experiences far outside my own. Exactly the kind of daughter Meaghan shows every sign of becoming.

Girls and Sports: A Winning Team

If you think sports are as vital to your daughter as to your son, you're right. Numerous studies underscore sports' benefits, both physical—weight control, cardiovascular health, reduced risk of breast cancer—and psychological. Adolescent girls who engage in sports, whether team or individual, enjoy better-than-average self-esteem and body image, less depression and higher grades, as well as lower rates of pregnancy and drug use. And, like boys, they learn competitiveness, teamwork and concentration, which can pave the way to adult success. One survey found that 80 percent of key women Fortune 500 executives had, as girls, played sports and thought of themselves as "tomboys."

Parents' support and personal sports participation are strong encouragements to girls. Organizations that offer resource materials: National Association for Girls and Women in Sport *(703-476-3452) and the* Women's Sports Foundation *(800-227-3988).* **LINDA SANDERS**

Dollars and Sense

BY SHELBY WHITE

Living through the experiences that inspired me to write *What Every Woman Should Know About Her Husband's Money* (Random House, 1995), I realized that we all need to know how to handle finances. And trust-fund babies, especially, need to develop a framework of values along with basic money-handling skills. Needless to say, this doesn't happen by itself. By the time children reach adolescence, their parents should be actively involved in helping shape their attitudes toward money. Thinking now about how best to convey your ideas and values regarding saving, investing, spending, vacations and inheritances will pay big dividends as your children grow older.

THE VALUE OF VALUES

Teaching children about money in an affluent society is like teaching them about sex in a promiscuous world. What you do matters as much as (or more than) what you say. If you judge people by the weight of their Rolex watches, so will your kids.

Teaching your kids about limits will, in the long run, teach them to manage financial independence. When teens see you buying Gucci, but you're sending them to the Gap, you have to explain about age-appropriate choices. Tell them they can buy more expensive clothes when they are older and earning their own money.

A few don'ts: Don't give your kids money or buy them the latest video or T-shirt just because you can afford to—and don't feel guilty about saying no. Check with other parents about spending levels, then set one that feels right for you. Don't put a price tag on love by giving your children expensive gifts instead of spending time with them. Also, don't give or withhold money as a sign of approval or disapproval. Don't, if you are divorced, outspend your ex-spouse in an effort to buy affection. Your kids will just play you against each other and wind up spoiled. Finally, don't make money a gender issue—it's not just for boys.

HOW TO HANDLE MONEY

A survey by The JumpStart Coalition for Personal Financial Literacy, a Washington-based education group, revealed that most twelfth graders aren't able to make critical money decisions. The message is clear: every kid needs hands-on instruction about budgeting, checking accounts and credit cards. Pierre Haber, Ph.D., director of the New York-based Psychology Society, says that giving kids an allowance helps them learn independence. Even if they waste it, they'll learn a lesson. An allowance for discretionary items, beginning when your child is 6 or 7, is a good start. (Giving one to younger kids might make money assume too much importance in their lives.) As kids get older, the money might start to cover lunch and clothing. Over time, they'll learn to make choices. A 12-year-old who gets $15 a week will think twice about spending $6 on candy; a 14-year-old with a clothes allowance will soon discover discounted Ralph Laurens.

Most experts say that kids should do chores without being paid for them, but some side with the chores-for-pay camp. Decide where you stand, set rules and stick to them. If your child wants more money, suggest part-time work. When I refused to raise my 12-year-old daughter's allowance, she found a dog-walking job.

Setting up a checking account for kids at 13 or 14 helps teach the basics; ideally, by the time they go to college they'll be able to handle their finances. In the New York City area, Republic National Bank allows children to open their own savings accounts with no minimum balance. Other banks nationwide offer similar programs; parents are usually required to cosign accounts.

Credit cards (with clear limits as to when and how they're to be used) are both a fact of life and a safety measure. You don't want your traveling teen to run out of money or gasoline. Cards are also convenient for parents; notes one mother of three teenagers, without credit cards, she would be forever going to the bank for cash, especially on vacations.

INVESTING AND INHERITING

If children stand to inherit a substantial amount of money, begin discussing it with them in their midteens. (Some experts advise starting earlier, depending on the situation. According to a U.S. Trust survey, the average age at which trusts kick in is 28; some, however, start as early as 18.) Be open about it. Let them know the amount of money involved, along with any conditions or restrictions. You can also introduce your teen to an accountant or financial planner. This removes some of the potential personal tension from family money discussions.

• PHILANTHROPY

Make charitable giving a family activity. Teach your kids to give money away early on; take them to a soup kitchen. As they move into their midteens, they can begin making suggestions about donations. The Tides Foundation (415-561-6400) has developed a screening program that funds projects for young donors. The Philanthropic Initiative (617-338-2590) works with families and young donors to design and/or run philanthropic programs that will reflect and reinforce their values.

• INVESTMENT CLUBS

The National Association of Investors Corporation helps organize clubs and offers *Investing for Life*, a guide to investments and personal finance for teenagers. (You may need to help teens decipher this; it's not light reading.) Cost: $30 (members); $45 (nonmembers). Information: (248) 583-6242.

• MUTUAL FUNDS

Stein Roe Young Investor Fund, founded in 1994, offers a Web site (younginvestor.com), a newsletter and a guide to reading annual reports. A growth fund stuffed with brand-name stocks such as Coke, Disney and Nike—but

Teaching children about money in an affluent society is like teaching them about sex in a promiscuous world. What you do matters more than what you say. If you judge people by the weight of their Rolex watches, so will your kids.

no guns, tobacco, alcohol or gambling stocks. Children younger than 18 must open a custodial account. (800) 403-5437.

• INTERNET SITES

The Web sites www.vanguard.com and www.younginvestor.com offer useful financial information. Many banks have Web sites geared to the young investor. Among these are swbankokc.com and commonwealthbank.com.

UNDERSTANDING MONEY

• READINGS

Zillions is the *Consumer Reports* magazine for kids. Tests products, warns against marketing gimmicks and ripoffs. Cost: $16 per year (six issues); (800) 234-2079.

Kids' Wall Street News is investment-oriented, with feature articles about young entrepreneurs. Cost: $19.95 per year (six issues); (800) 998-5400 or www.kwsnews.com.

• INTERNET SITES

www.wa.gov/ago/youth is aimed at savvy teen consumers.

• BUSINESS CAMPS

The Breakers, in Palm Beach, offers a one-week summer-camp program geared to the 6- to-12 set, with one hour a day devoted to learning about investing and saving. Parents must be hotel guests or Breakers Club members. (888) BREAKERS.

Julian Krinsky Entrepreneurial Business Camp, Haverford, Pennsylvania; (800) 879-8578. At $2,900 for a four-week summer semester (ages 12 to 18), this program is for the truly ambitious. MBA's teach the basics of entrepreneurship, accounting, ethics and business law. Although it's coed, boys outnumber girls.

• GAMES

The Brent *Cash Channel* has a kit called Money Management for Kids ($24.95)—with instruction cassettes and a manual designed to help kids ages 5 to 15 learn to save, set goals and become financially responsible. There's also a Web site: www.cashunversity.com.

• READINGS FOR PARENTS

Dr. Dollar's Money-Smart Kids, by Janet Bodnar (Kiplinger Books, 1997, $15). Answers basic questions.

Raising a Money-Smart Child, a twelve-page pamphlet packed with information about money management, saving, investing and spending, is available from The JumpStart Coalition for $1. Call (202) 466-8604 to order.

"Money and Children," issue #9 of the quarterly journal *More Than Money*. More Than Money, 224 Alder St., Eugene, OR 97405; (800) 255-4903.

For other personal-finance resources sorted by age and category, check JumpStart's Web site: www.jumpstartcoalition.org, in the Clearinghouse section.

• BOOKS FOR KIDS

A Penny Saved, by Neale S. Godfrey (Simon & Schuster, 1996; $12). Addresses how you move from being a citizen of the household to being a citizen of the larger community. Includes exercises on budgeting, earning money and investing.

The Totally Awesome Money Book for Kids and Their Parents, by Adriane G. Berg and Arthur Berg Bochner (Newmarket Press, 1993; $10.95). How to spend, save and invest money, for ages 10 and older.

You Can't Sell Your Brother at the Garage Sale: The Kids' Book of Values, by Beth Brainard (DPT Trade Paperbacks, 1992; $11.95).

Mira Kirshenbaum also recommends outside employment. "Summer jobs and limited after-school employment should be taken for granted" (see "Instilling the Work Ethic," page 109). Also, consider having your kids take out college loans—"even if you can afford to buy the college. They'll take their education much more seriously if, to some extent, they're paying for it."

Drugs and Alcohol

"Talking openly with your teen about drugs and alcohol might upset you, but full and open communication is the single best way to prevent serious problems," says Kirshenbaum. "That means *listening*. If he tells you things that upset or scare you, ask what his own thoughts and feelings are. That saves a boring lecture that he'll tune out. Then say, 'Look, I've got to tell you how I feel about this,' and talk about feeling angry or scared or whatever. Your kid will more likely listen to you if you've listened to him." Stay nonjudgmental and nonaccusing, but make clear the real-life consequences of drug use. "Find out the steps your kid's school takes with a student who's identified as having a drug problem," says Kirshenbaum. If you know or suspect your teen is abusing alcohol or drugs, don't wait: promptly take steps to deal with it (see "The Drugs Problem," page 111).

Issuing dire warnings against drugs can feel hypocritical to baby boomers who came of age in the freewheeling Sixties. "There are three issues here," says Dr. Koplewicz. "First, '60s marijuana was not nearly as potent as today's marijuana, which is often treated with other drugs. Second, starting marijuana at 18, as people did in the '60s, is very different from starting at 14. Third, the earlier you smoke cigarettes, the higher the risk you'll smoke pot; the sooner you try marijuana, the higher the risk for cocaine." Perhaps surprisingly, he advises that, even if you once used drugs, you should—shall we say—*pretend* you didn't. "Be consistent, and be firm: 'I didn't do drugs, and I don't want you to.'"

Whether you use this approach or another, he says, be careful to preserve your bond with your teenager. "Then if your kid does get drunk, he can call you and say, 'I need a ride home,' or 'I'm in an uncomfortable situation.' Remember, many times kids *want* to be let off the hook; it's a tremendous relief when parents step in."

Sex

Communicate, communicate, communicate. Don't rely solely on your teens' school sex-education program, says Horace Mann's Eileen Mullady. "I'm sure most school programs are adequate, but they aim for the middle, and kids vary widely in their readiness and ability to talk about sex." Don't be lulled by an adolescent's air of self-assurance; make sure he knows all the necessary facts, from basic anatomy and reproduction to contraception and sexually transmitted diseases. Be sure to bring up gender expectations; these can bend or break a teen's self-image (see "My Girl," page 104), as can concerns about sexual orientation. (If you feel uncomfortable talking about sex with your teen, join the club. If you feel truly paralyzed, ask a trusted family member or friend to help, or enroll your child in the sex-education courses offered by many Planned Parenthood clin-

ics and by some churches.) The key, as with drugs, is to talk in a way that leaves the door open to future discussion.

Parents also need to discuss the merits of abstinence and the dangers of disease transmission through oral sex or intercourse. Sex is baby boomer dilemma number two. "These parents don't want to be hypocrites, but there are three things to keep in mind," says Dr. Koplewicz. "First, kids today are starting sex earlier. Two, there's a lethal virus, HIV, out there. Three, you need to keep proper boundaries. Remember, you're not friends." Sharing your sexual history is not helpful; nor is dithering. "Some very elegant studies show that with kids, it's bad to be ambivalent," says Dr. Koplewicz. "You should talk about sex as an expression of love and affec- ►111

Surviving the Successful Parent

BY ESTHER BERGER

When my first book, *Money Smart* (Simon & Schuster), was published in 1993, my then 15-year-old son Michael picked up an advance copy from our kitchen counter and said: "Is this your book, Mom? Cool, what's for dinner?" As an author, I felt a bit deflated, but as a mother, I knew I was doing something right. Michael was—and is—very much his own person, with high regard for his mom, but also a healthy sense of perspective.

"Each child needs to develop his or her own identity, and not be overshadowed by parents' achievements," says psychologist Lee Hausner, Ph.D., author of *Children of Paradise: Successful Parenting for Prosperous Families* (J.P. Tarcher, 1990; $18.95). "This is especially true when Mom or Dad is a prominent public figure and expectations galore attach to the children."

In *On the Edge of the Spotlight: Celebrities' Children Speak Out About Their Success and Struggles* (William Morrow, 1981; $12.95) Kathy Cronkite writes of constantly being asked "what it's like to be Walter Cronkite's daughter" and of feeling the "pressure of people always expecting me to be intelligent, well informed and as politically aware as my dad." Indeed, as psychologist M.H. Stone has written, children of the famous "may feel hopeless about measuring up to a parent whose fame rests realistically on extraordinary skills." They may adopt a "why try?" attitude, their petulant self-absorption masking their real despair.

How can prominent parents avert this? "By raising children whose self-esteem is not predicated on being the best, the smartest or the prettiest," says Lee Hausner. "Children must feel approved of before they can experience their own worth as individuals." And parental support gives children the courage to engage in the trial and error that's so crucial to discovering their own talents.

In powerful, affluent families, it is especially important to avoid constantly instructing children in "the Smithson way" or "the Rubenstein way." Let them experience the consequences of their own behavior, and try not to open doors for them too easily or quickly. Rather than using their celebrity to get a child into prestigious private schools or plum jobs, experts say, parents do better to make an introduction where appropriate, then let a child stand on his or her own merits.

Children of privilege often feel an exaggerated sense of entitlement, particularly if parents model this attitude themselves, buying their way out of trouble or constantly running interference at school. If a child is caught lying or stealing, for example, his parents must resist the urge to bail him out (literally or otherwise) by asking that he be let off "just this once." "Parents must teach children that being special means that you are special as an individual, not because you're someone's son or daughter," stresses Hausner.

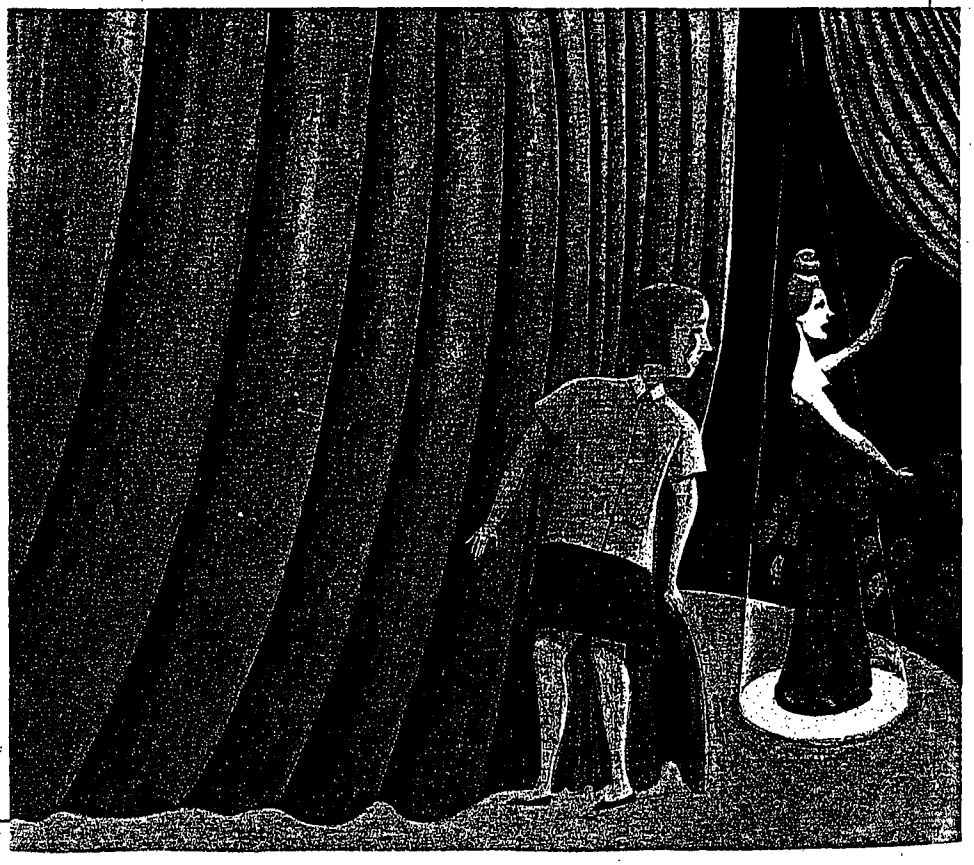
Most of all, psychologists agree, notable parents must learn to check their public personae at the front door. Negotiating a multimillion-dollar deal or guesting on CNN may out-glam listening to an 11-year-old's prepubescent woes or helping her older brother prepare for his SAT exam. But at home, celebrity parents should just be Mom and Dad, loving their children for who they are—not who they're expected to be.

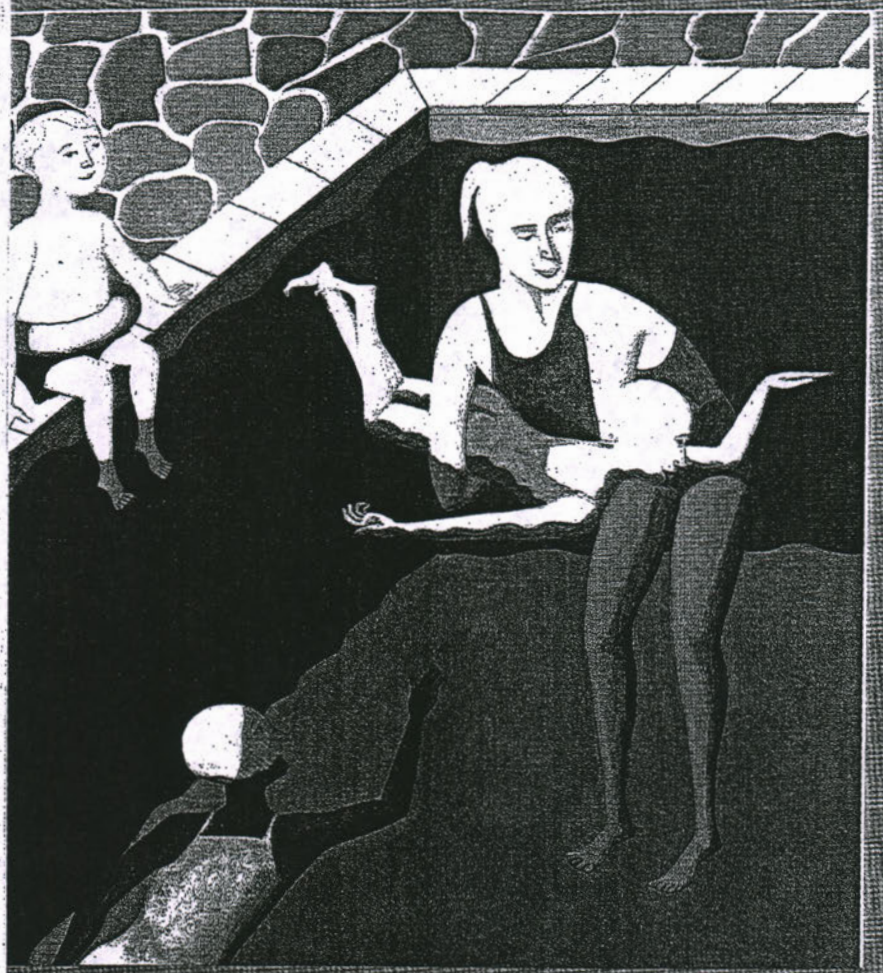
READINGS

***Children of Fast-Track Parents*, by Andrée A. Brooks (Penguin; $8.95).**

SEMINARS/WORKSHOPS

Dr. Hausner and other counselors offer seminars on affluent parenting to corporations and professional or civic organizations.





Instilling the Work Ethic

BY PATRICIA MCCORMICK

All children need the skills, self-esteem and feelings of competence that come from holding a job, and this is especially true for children of affluent or very successful parents," says Richard Gallagher, Ph.D., director of the Parenting Institute at the Child Study Center at NYU Medical Center in New York. Children who are not expected to work, says Gallagher, "are likely to see themselves as ineffective or ineffectual outside of school or sports. They may also become cynical or unappreciative of others' contributions—or worse, they may expect to be taken care of." And though many hardworking, successful parents assume that their example automatically rubs off, this may not be so. "Affluence can easily sap a child's ambition," says Thomas Olkowski, Ph.D., a Denver psychologist who specializes in family therapy.

How do you instill a work ethic in your teenager? You can start by telling your child its time he assumes some responsibility for paying for CDs, movies and other things that normally come out of his allowance," says Olkowski. From there, especially for older teens, getting a summer job is a natural next step.

You must signal the importance of your teen's job by planning summer camp or vacations around it. You'll also need to decide whether a job at the local ice-cream parlor or mall fits the bill. "Many parents think a summer job should be serious and career-oriented," says Olkowski.

But working with the public in a service job also can be wonderful because it gives a youngster a chance to interact with all kinds of people—people he would never meet otherwise." And being hired to help with pony camp at the local stable or with pee-wee tennis at your club can give a sense of what it's like to be needed, to know that someone is counting on you," notes Olkowski.

"I don't generally believe in paying children for routine chores," he adds, "but those too young to work outside the home can take on special projects you'd normally hire someone else to do, like organizing family photos, painting the playroom or weeding the garden."

You may want to consult a service that specializes in helping children find meaningful jobs, internships or community-service experiences (see list below). "Depending on the child's age and experience, we can find volunteer work doing construction at a community center, on an Indian reservation, working with the elderly, grooming ecological trails in various wilderness areas or assisting with marine-animal research," says Margo Ross of Trips on Trips (212-722-3962). Finding internships can be challenging. Ross encourages parents to check with their own contacts and resources for jobs at museums, government agencies or businesses. Other good sources: *Peterson's Summer Opportunities for Kids and Teenagers* ($26.95) and *Peterson's Internships* ($24.95). On-line information is available at www.petersons.com.

Perhaps the best place to start is with your child's own interests. "My favorite story is about a 15-year-old whose hobby was magic tricks," says Olkowski. "He needed money but didn't want to work at a fast-food restaurant. So he started his own business performing magic at children's birthday parties."

COMMUNITY SERVICE

In looking for teen-friendly volunteering possibilities, your first stop should be the local volunteer bureau. **OTHER SOURCES:**

Youth Service America, 1101 15th St., NW, Washington, D.C. 20005; (202) 296-2992. Its Web site, www.servenet.org, provides information on regional/local service projects.

Books: *The Kid's Guide to Service Projects: Over 500 Service Ideas for Young People Who Want to Make a Difference*, Barbara A. Lewis (Free Spirit Publishing, 1995, $10.95).

Teen Spirit

BY CHRISTINE LOOMIS

Finding positive ways to connect with your teens can be frustrating—but it is possible if, instead of insisting on your own preferences, you join your teenagers in activities they like.

Because teens are usually creative and enthusiastic about the arts, try a photography, painting or ceramics class together. (One advantage of a class is that it puts you both on an equal footing, thus eliminating an area of potential conflict.) Sports are another natural connection. My dad and I golfed together from the time I was seven until I was over 40, and though as a teen I would never have admitted it, I was profoundly grateful for those days when we laughed and came to better understand one another on the fairway. I hated rock climbing with my own teenage daughter, but on skis, horseback or the putting green we forget our differences and relax. Or consider working out together or introducing a teen to spa treatments. An afternoon at the gym or health club fosters one-on-one time and good health through action rather than lectures.

That adolescents roll their eyes at talk of family vacations is no reason not to go—but remember these caveats. Either go where other teens are guaranteed to be or let your child take a friend. Choose a place with abundant sports, since adolescents are high-energy travelers (except in the early morning, when they're comatose—don't plan events then). By a resort or cruise ship, in these safe environments, you can relax while your teenagers achieve (if only briefly) the independence they so crave.

Six Places that Love Teens—And Vice Versa

• **Four Seasons Resort, Maui**, 3900 Wailea Alanui, Wailea, Maui, HI 96753; (808) 874-8000. Hawaiian elegance goes hand in hand with sports: free scuba clinics for kids ages 12 and up; eco-snorkel tours for guests 8 and up. Portable stereo equipment is available on loan at no charge.

• **Resort at Squaw Creek**, 400 Squaw Creek Road, P.O. Box 3333, Olympic Valley, CA 96146; (530) 583-6300 or (800) 327-3353. A four-season resort with ski and ski-out facilities and snow tubing in winter, a mountain adventure program for children and teens in summer. The 40,000-square-foot Health Center & Tennis Club has an ice rink, indoor and outdoor climbing walls, tennis courts, a swimming lagoon and, for the daring, a bungee tower.

• **The Peaks Resort & Spa at Telluride**, P.O. Box 2702, Telluride, CO 81435; (970) 728-6800 or (800) 789-7669. Few resorts so beautifully combine pampering and outdoor pursuits. The spa offers treatments specifically for teens. Or sign up for a day of family adventure: hiking, climbing, snowshoeing or cross-country skiing.

• **Boca Raton Resort & Club**, 501 E. Camino Real, P.O. Box 5025, Boca Raton, FL 33431; (561) 395-3000 or (800) 327-0101. Teenage guests mingle at the Boca Raton 33-92 Club (ages 14 to 17). Serious junior tennis players (ages 9 to 18) can try the Nike Tennis Camps in July and parents and teen golfers will enjoy the new Nicklaus Flick Golf School.

• **The Cloister**, Sea Island, GA 31561; (912) 638-3611 or (800) 732-4752. At the five-star Cloister, a place where generations of families have gone to relax and reconnect, teens can join peers for tennis mixers, evening get-togethers, kayak tours, golf and more. Popular with families: shooting school.

• **The Bitter End Yacht Club**, North Sound, Virgin Gorda, British Virgin Islands; (800) 872-2392. Outside the U.S. and Canada: fax (888) 329-2392. A guaranteed antidote to stress, the get-away-from-it-all Bitter End boasts a superb sailing school and windsurfing classes taught by a staff adept at working with all ages. Stay on land or in live-aboard yachts afloat on the stunningly clear BVI waters.

The Drugs Problem

BY MARC WORTMAN

When a teenager is using drugs, most parents are reluctant to face it. "There are a lot of small crises that parents don't want to see as symptomatic of a drug problem—the slamming doors, the petty shoplifting, the school troubles," says "Barbara," the CEO of a major New York City advertising firm. "But if they knew what was coming later, believe me, they'd act early." For her, the big crisis came when her seventh-grade son was thrown out of school for selling drugs.

Whether you suspect experimentation or more serious drug use, sticking your head in the sand is a bad idea, says Mitchell S. Rosenthal, M.D., president of Phoenix House Foundation, the nation's largest private, nonprofit substance-abuse service organization. "Parents need to take a stand," says the child psychiatrist and author of *Drugs, Parents and Children: The Three-Way Connection* (Houghton Mifflin, 1972). "Any drug that alters consciousness is toxic to a young person's growth, development and maturation."

Studies show that warning your children about drugs early and often is the best prevention. Remember that children are being offered drugs at ever earlier ages, and that even older children need—and want—parental guidance and authority. "The pressures on well-to-do kids are in some ways even harder," says Barbara. "They have more choices, and drugs are everywhere. It's nonsense to think you can flee the problem."

Make sure you know your child well. Drug use often arises out of internal vulnerability. "Kids who are troubled about themselves—slow learners, self-doubters—are at greater risk," Dr. Rosenthal says. Also, assess what is happening in your family. Life changes such as marital strain or breakup, job loss or a move to a new home or school can dramatically increase your child's vulnerability to drugs. Remember, too, that kids often encounter drugs in and around school. Your child's teachers may be the first to spot signs of trouble, so you should keep in touch with them. In part, it was discouragement with the growing challenges of sixth-grade schoolwork that first led Barbara's son to try drugs. (Since graduating from a Phoenix House program, he is now drug-free.)

"If you suspect a substance-abuse problem," says Dr. Rosenthal, "don't be afraid to be very direct. Say, 'I'm really worried that drugs have become a part of your life. Can you tell me how you see it?' Asked in that way, the question won't appear too tough or judgmental. If your kid says, 'Why should you worry?' you can present evidence of a problem. If you're really not sure whether your child is into drugs, you can ask your physician to do a drug test. And if you're stonewalled or troubled by continued problem behavior, then it's time for a professional consultation. Reach out to a substance-abuse specialist or agency in your community." A specialist can make recommendations as to how to intervene and what kind of treatment your child needs. Most communities have drug counseling, after-school programs and schools whose curriculum includes rehabilitation. Very severe problems may require live-in treatment. "The rule of thumb," says Dr. Rosenthal, "is that you have to seek help that is going to result in your youngster becoming drug-*free*. You don't want the kid going to therapy and still using drugs." And be prepared to get personally involved. "We won't accept a child into treatment unless the parents participate," he says. "We've never seen an adolescent drug problem in which there weren't significant issues that needed to be resolved between the parent and child. That's true even with the most loving parents."

GETTING HELP

- Dr. Rosenthal advises that parents first contact one of the information centers listed below and then seek assessment and counseling locally.
- *Phoenix House*, 164 West 74th Street, New York, NY 10023; (800) DRUG-HELP or www.drughelp.org.
- *Partnership for a Drug-Free America*, 405 Lexington Avenue, 16th floor, New York, NY 10174; (212) 922-1560 or www.drugfreeamerica.org.
- *Parents' Resource Institute for Drug Education (PRIDE)*, 3610 Dekalb Technology Parkway, Suite 105, Atlanta, GA 30340; (800) 853-7867 or www.prideusa.org.
- *National Clearinghouse for Alcohol and Drug Information (NCADI)*, P.O. Box 2345, Rockville, MD 20847; (800) 729-6686 or www.health.org.

Treatment centers specializing in adolescent substance abuse:

- *Hazelden Center for Youth and Families*, 11505 36th Avenue North, Plymouth, MN 55441-2398; (800) 833-4497.
- *The Phoenix Academy*, P.O. Box 4058, Stoney Street, Shrub Oak, NY 10588; (914) 962-2491.

tion, making clear that you don't want your son or daughter to have sex for sex's sake," he continues. "Recently, a boy proudly told how he got a girl to give him oral sex—he'd heard she'd done it for some other boy, so he told her, 'You're my best friend, aren't you going to give me what you gave him?' He then told some other girls, and *they* felt pressured to do it also. He clearly was not in love, or even in like, with any of them. That's a failure of parenting."

With sex, as with drugs, parents must stand ready to lend a hand if necessary. "When my daughter Courtney turned 12, I gave her a wrist watch and told her, 'This is your new best friend,'" says Adelaide Hornberger, an active community volunteer in San Francisco. "I told her that if she ever found herself in an uncomfortable situation, she should look at the watch and say, 'Oh my God, I've got to go home!' Our children know that whatever situation they're in, they can just call us. We never go anywhere without leaving them our number."

Virtual Reality: the Good, the Bad, the Ugly

"The whole culture and the ways relationships are described in books, music and film have changed," says Eileen Mullady. Good parenting means not turning your back on the media flood with its flotsam and jetsam of values, but instead helping your teenager wade through it. "To teach kids to sort through things, I need the same information they're getting," says Mullady. "I know all the music the kids listen to; I watch all the garbage on TV. I'm very much against censorship, so I have to talk to them."

The price of media-savvy parenting is eternal vigilance. "Film ratings are great, but parents have to pay attention to them," says

Dr. Koplewicz. He should know: at his middle son's birthday party, he and his wife sat in the movie theater surrounded by his son's twenty-five 11-year-old guests, watching a steamy sex scene from the R-rated *Jerry Maguire*. "I was thinking, We're dead," he ruefully recalls. "And as we left the theater, a bunch of *strangers* yelled at us, 'This is not an appropriate film for youngsters!' We apologized to the kids' families, but there's no doubt we goofed."

A Parent's Progress

In the course of their journey, parents, like teens, make many discoveries. Some are ecstatic, some disappointing, some bittersweet —as in the realization that, when you're a parent, it's truly hip to be square. Elegant Robin Hubbard notes that her kids call her "Mother Hubbard," then laughs charmingly. "On bad days, it's *Old* Mother Hubbard." But the journey's pleasures far outstrip its perils. The greatest joy, perhaps, is that of successfully navigating a new terrain—one famed for its challenges.

"Time, time, time is needed to be a good parent," Dr. Koplewicz sums up. "Successful people know that most tasks are much more difficult than they seem. People don't make a million dollars easily; they don't graduate from medical school or become Nobel laureates easily. Good parenting is not done easily, either." ✱

Books mentioned throughout are available by calling (800) 962-6651, ext. 1115.

The Troubled Teen

BY MARC WORTMAN

Everyone needs to be left alone from time to time—but a teenager who shrinks from family and friends or avoids school or important social activities may well be struggling with problems beyond the normal stresses of adolescence. Granted, it can be hard to tell. As Boston adolescent-medicine specialist Lydia A. Shrier, M.D., M.P.H., reminds parents, "How many times did you go upstairs and slam the door?" More often than not, a teen's moodiness is *simply that*. But if it *continues for more than a few days*, or if it combines with behaviors such as fighting, overly aggressive sexuality or emotional outbursts, a child may need professional help.

The trouble is, isolation or aggression can signify a multitude of woes, from physical illness (hormonal imbalances, brain tumors or even reactions to medication) to mental/emotional conditions (depression, anxiety or other mood disorders, eating disorders, undiagnosed learning or attention disabilities, substance abuse). It may also reflect low self-esteem or be a reaction to trauma such as divorce, illness, violence or sexual abuse. Adolescents who have difficulty relating to others—misreading nonverbal cues, constantly interrupting or standing uncomfortably close during conversation—may suffer from a personality or thought disorder. It can take one or more experts to accurately assess a child's condition and recommend the proper treatment. Depending on the diagnosis, this could be individual or group talk therapy, a support group or a pharmaceutical regimen.

If you're concerned, ask your child's teacher, school counselor or psychologist whether he or she has noticed any social or behavioral changes or problems. You should also consult your primary-care provider, says Dr. Shrier: "Some behavior changes may involve physical conditions." For instance, says "Suzanne," a Napa Valley vintner, when her teenage son developed schizophrenia, the first warning sign was a change in his sleeping patterns; he also grew quick to anger and increasingly withdrawn. "He was always much less social than the rest of us," she recalls, "and these seemed so much the problems common to any teenager. I now know they were symptoms."

If your child suffers from a mental or emotional disorder, she says, "You need to network to find the right people and doctors." Her discussions with her family physician and with several friends led her to a psychiatrist who identified the problem and began treatment. "Getting the right diagnosis is absolutely critical," she says.

WHERE TO GET HELP

Your child's physician should make an assessment and, if necessary, refer you to the appropriate specialists or services. Other sources: *The American Academy of Pediatrics*, www.aap.org. For a copy of AAP's brochure "Surviving: Coping with Adolescent Depression and Suicide," write to Department C–Depression, P.O. Box 927, Elk Grove, IL 60009. *The National Alliance for the Mentally Ill (NAMI)* offers advice and educational and referral services, and sponsors support groups. 800-950-NAMI. *The National Alliance for Research on Schizophrenia and Depression (NARSAD)* provides information and fact sheets on the warning signs of suicide. (800) 829-8289.

REMARKS OF DONNA SHALALA
NYU CHILD STUDY CENTER OPENING

Congratulations to New York University and the Child Study Center for taking an idea whose time has come, and making it a reality.

If there is one human trait we all share, it's our love for children and desire to raise them healthy and happy. God knows it's not easy. As a philosopher said, children are natural mimics -- they act like us in spite of every attempt to teach them good manners. But being a parent today is especially tough, because parents are drowning in a sea of advice on the right way to raise children. Just look in the bookstore under parenting. You've got, "10 Most Common Mistakes Parents Make." "101 Ways To Be A Special Dad." "365 Ways to Build Your Child's Self-Esteem." "1001 Things To Do With Your Kids." And my personal favorite: "101 Ways To Get Your Adult Children To Move Out."

With all this advice, the question is, what's the answer? The latest theory about child-rearing is like Mark Twain's description of the weather in New England: Wait a minute -- it'll change. Just think of all the conventional wisdom we've accepted and rejected. Freud was right. Freud was wrong. Spock was right. Spock was wrong. Spock was right after all. Children are durable. Children are delicate. It's nature. It's nurture. It's nature and nurture. And now there's the new debate about the influence of peers versus parents, suggesting that Mom and Dad are nothing more than befuddled bystanders. The changing winds of child psychology are enough to drive parents batty. They want to do everything right, but they're afraid of doing everything wrong.

There's nothing wrong with the steady progress of parenting advice. Fifty years ago, most parents didn't think about child psychology, let alone developmental research. Conventional wisdom didn't go much beyond, "spare the rod and spoil the child" -- another theory I'm glad we've debunked. Before the National Institutes of Health began conducting research into the emotional and behavior disturbances of young people, we didn't think children could suffer from depression. Now we know they can.

We also know when it comes to health issues as complex as child psychology, theories not anchored in the facts are vulnerable to prevailing winds. And to get the facts, we need solid research. Research confirms what our hearts tell us -- that children need adult love and supervision. As one 15-year-old said, "I've learned that although it's hard to admit it, I'm secretly glad my parents are strict with me." Research has also reveals what our eyes are missing -- that we're not doing enough to recognize mental health problems in children. In five studies funded by our National

Institute of Mental Health, fewer than 20 percent of children at risk for mental disorders were spotted by their primary care providers as needing help. Research also tells us that mental health problems in children, left untreated, can destroy their chances to succeed in school, in society, in life. And child abuse can inflict not only an emotional wound that doesn't heal -- but also permanent brain damage. Research also tells us that more than one in 10 young people may be affected by mental disorders that involve moderate to severe impairment.

Fortunately, research has also debunked the belief that depression in children is a stage they'll grow out of. Or that some children are just plain "bad." We know it's not their problem. It's our problem when children are at risk. It's our problem when violence is the leading cause of death for teens and young adults. And their death rate from homicide doubled between 1970 and 1997. It's our problem when suicide kills young people. When one out of five high school students thought seriously about suicide. When one in 13 young people say they've tried it. And when, every day, several actually do it. And it's our problem when so many childhood problems stem from mental health problems. OCD -- Obsessive Compulsive Disorder. ADHD -- Attention Deficit Hyperactivity Disorder. Or even PTSD -- Post Traumatic Stress Disorder. Research tells us these problems are not inevitable. They can be identified, prevented and treated.

Solid research not only helps to anchor our theories about health -- both mental and physical -- it also points the way to real solutions. That's why, in his State of the Union Address last January, President Clinton called for an historic national investment in scientific research. And in the federal budget he just signed, the National Institutes of Health will receive the largest single dollar increase in its history -- two billions dollars, a 15 percent increase.

These funds will help to stimulate breakthrough research into child development and mental health. For starters, we're teaming up with Head Start in a research program to improve our ability to identify early mental health needs, and how to meet them. We're teaming up with the Casey Family Program to develop a project called Starting Early Starting Smart, which looks at bringing mental health services to child care and child health care settings. We just received 40 million dollars to improve mental health services in schools to help children with emotional and behavioral disorders. We're also making sure that children are no longer left out of clinical research for new medical treatments. And we've just sponsored 15 centers for research into pediatric pharmacology, seven of which will focus on medications for children with mental health problems.

But as Dr. Koplewicz reminds us, childhood mental health is still the Rodney Dangerfield of medicine -- it doesn't get enough respect. That's why NIH is hosting a special "consensus development" conference next week that will spread the word on Attention Deficit Hyperactivity Disorder. And that's why, as we cut this ribbon, I want to congratulate New York University and all its supporters for devoting the funds, faculty and other resources to create this Child Study Center.

As Dr. Koplewicz explained, this Center will use creative ways to help us answer some of the most difficult questions about healthy child development. Our nation's future depends on the work you do. Because our future is in the hands of an 8-year-old boy who needs our help because he can't sit still in class, can't pay attention and can't read. And our future is in the hands of a 15-year-old girl who needs our help because she's depressed and doesn't know if life is worth living.

Our future is in our children's hands. Their future is in our hands. Hands that must join together and build a circle of concern and care around every child. It takes parents, doctors, public health experts, researchers, corporate, community and religious leaders, teachers and schools, law enforcement and government at all levels. Children's future is in all of our hands. And thanks to the Child Study Center, their mental health will be in far better hands. Thank you.

FIRST LADY HILLARY RODHAM CLINTON
CHILD STUDY CENTER
NEW YORK UNIVERSITY'S SCHOOL OF MEDICINE
DECEMBER 1, 1998

Thank you, Mr. Corzine (chairman and CEO of Goldman, Sachs & Co, and 1998 Gala Chair ~~and appointed by President Clinton of member of Capital Budget Commission~~) for that kind introduction. It's a great pleasure and honor to join you and Dr. Harold Koplewicz, director of Child Study Center; Brooke Neidich, chair of the Center, and all of you here this evening. I want to begin by offering my heart- felt congratulations on the launching of this Child Study Center, which I had an opportunity to visit briefly this afternoon. Your vision to combine scientific research, education and community outreach has made this the most comprehensive child mental health facility in the region -- and one of the largest in the nation. I am truly honored to receive the award you are bestowing on me this evening.

But it is what all of you do -- on behalf of our young people every single day -- that deserves our deepest appreciation and gratitude. For so many years, when we talked about what children needed to grow up strong and healthy — we thought primarily of their physical well-being. By devoting this Center exclusively to promoting the mental health of children and adolescents -- you ~~have~~ helped complete the circle of comprehensive services that we now know young people need to grow and learn and flourish. Perhaps most important of all, the Center has placed scientific research at the heart of its work with parents, educators, pediatricians, and mental health providers — where it belongs.

The fact that such a revered institution as the NYU School of Medicine -- which has been one of the nation's pioneers in public health and research for over 150 years -- has made this level of commitment to the mental health of children and adolescents underscores the magnitude of the challenges before us. ~~Today, it's estimated that~~ 12% of ~~the~~ our population under the age of 18 suffers from a psychiatric illness — and that 8 million of America's children are in need of help. Here in New York state — it's estimated conservatively that 80,000 young people will suffer without treatment -- many because their families can't afford it. The problem becomes even more pressing when we look at other indicators that contribute to poor mental health — children living in poverty; those living in foster care; those who are abused and neglected; those who are falling behind in school.

But the existence of this Center also reflects how far we've come over the years.

As some of you know, I first became interested in ~~this subject~~ child development when I was in law school, and I had the chance to study ~~children~~ at the Yale Child Study Center ~~in New Haven~~. I was privileged to work with one of the pioneers in the field of infant behavior, Dr. Sally Provence. Today, I still have vivid memories of the gentle and subtle ways that Dr. Provence would elicit information from parents and help them establish better patterns of relating to their children.

Mental illnesses confound, they disable, and they impoverish patients and their families.

Later on, in my work with children's organizations such as the Carnegie Council on Children, I watched many dedicated men and women work to apply current scientific knowledge and research in the public policy arena. All of these experiences reinforced my belief in the mutuality of research and policy. We simply cannot have one without the other.

One need only look at the progress we have made — and how we have made it — in areas affecting children to appreciate the connection. Could we have lowered the rate of infant mortality, eradicate childhood diseases like measles and polio, or developed and released new drugs and therapies without a nexus between medical science and policy?

move mental health section

an

The tragedy of mental illness in children and adolescents is all too familiar part of our lives -- taking place in families that cross every economic and social boundary. I've read some of the heart-breaking words of the children who are part of the Center's "Childhood Revealed" book of drawings. "I just feel like a piece of me inside is missing" says 11-year old Andy. A 14-year girl draws a discarded umbrella in the rain — and talks of watching her mother abuse drugs. All of us are affected — parents and children alike. ~~Who here hasn't known friends or family members who have run the gauntlet of testing, therapy, and tutoring — desperately trying to find out what they can do to bring their child out of a depression, or exhausted by their efforts to steer a child away from drugs? Who hasn't known teachers -- even the best ones -- who haven't been given the skills to cope with at risk kids -- or the information they need to ensure those students get the services they need?~~

and the work of the Nat'l Institute on Mental Health

Today, thanks to centers of research and education like this one — we have made major strides toward erasing the myths and misconceptions about children's mental health. And we've learned not only how to identify and treat child and adolescent mental illness more effectively — but how to help prevent it in the first place. The fact that parents are major supporters of this new Center says volumes about the need for more support and treatment -- and the hope that you have already given to children and families across the region.

Research tells us that problems are not inevitable -- they can be identified, prevented and treated.

~~Much of what we've learned~~ over the past decade ~~has to do with the connection between a child's earliest experiences — and the development of his or her capacity to grow and learn and love~~. Last year, ~~as many of you know, we held a~~ White House Conference on Early Childhood Development and Learning. We wanted to give the leading experts in the field of early childhood development — the scientists, pediatricians, researchers, and others — the opportunity to explain their discoveries, and to put this invaluable body of knowledge at the service of America's families, doctors, and educators.

The President and I hosted the first-ever

policy-makers

~~As a result of scientists and researchers like many here this evening, these discoveries have taken a quantum leap over the past fifteen~~ years. It seems astonishing now that we used to think that a baby's brain's structure was virtually complete at birth. Today, we understand that it's a work in progress — that everything we do with a child has some kind of potential physical influence on that rapidly forming brain. ~~We've finally debunked the myth that it's either~~ nature or ~~nurture. As a leading psychiatrist said recently — "It's not a competition, it's a dance."~~ And ~~we now know that dance begins not at birth — but almost as soon as the baby is conceived~~.

Similarly, we used to think that children could suffer from emotional...

we have learned a breathtaking amount about the importance of children's earliest experiences to their rapidly forming brain and their healthy development. *

A child's earliest experiences, their relationships with parents and care givers, the sights and sounds and smells and feelings they encounter, the challenges they meet, determine how their brains are wired. And that brain shapes itself through repeated experiences. And as this audience knows so well — these early patterns can become permanent -- with the first three years of life being the most critical time. Bill and I loved reading to Chelsea when she was young. But we had no idea back then that we were literally turning on the power in her brain, firing up connections that would enable her to speak and to read. We now know that activities like hearing a song or a story, getting a hug after falling down, knowing when to expect a smile — are literally laying the foundation for how well a child will learn and grow for a lifetime.

The implications of this new knowledge on brain development for society as a whole are enormous. Because again as you know all too well — the experiences of young children have a tremendous bearing on whether or not they will grow up well-adjusted or anxious and depressed individuals, peaceful or violent citizens, focused or undisciplined workers, attentive or detached parents themselves. Whether, in other words, they will be able to fulfill their God-given potential, or be hobbled by problems that will rob them of the joy and productivity of a full life.

The implications of this and related new knowledge and research for policy makers is also tremendous. Those of us who have been pushing for a national commitment to ensure quality, safe, and affordable child care and expanded early childhood development programs are now armed with the knowledge that those first three years of life are critical to the development of a child's brain and his or her ability to succeed over a lifetime. Those who have worked tirelessly to ensure fathers become more involved in the raising of their children are now armed with the knowledge that children whose fathers help care for them are less likely to become violent, and have higher I.Q.s. Doctors and nurses who have instinctively known the importance of holding and caressing new borns — particularly premature babies — are now armed with the knowledge that babies who are regularly massaged gain more weight — and are discharged earlier from the hospital — saving both money and heartache.

At the White House conference, we learned about the depth of the hunger for this kind of information from parents, advocates, day care workers, educators, doctors and policy makers. Part of what is so exciting about what this Center is doing is your focus on translating scientific research into practical skills for those who touch the lives of children every day. Because until that knowledge is part of our everyday approach to how we deal with children, all the scientific discoveries in the world won't help our children cope; or learn; or overcome their problems.

I want to commend the Center's important outreach efforts -- like your programs that help parents become better parents -- and the new middle school curriculum that will enable teachers to improve how they manage the classroom -- and identify at-risk students. I also want to encourage your national public awareness campaign on child and adolescent mental disorders. We still have a long way to go in bringing these difficult issues out into the open, and we must begin by doing a better job of educating parents and teachers and the entire community. Information, research, and a major dose of honesty is the only way we can begin to diminish the fear and ignorance that only perpetuate the problems.

to benefit our nation's children

Much of this invaluable information and knowledge is the result of the work of scientists, doctors, and researchers like many of you here this evening. But we have also gained it through the work of the federal government. The government supports more than 90% of all children's research. Since 1993 — our investment in this work at the National Institutes of Health has increased 25%.

single dollar increase for NIH in its history.

This year, my husband signed into law the largest expansion of research .... in our nation's history. And some of those funds will focus on .....

Another top priority for this Administration is to sharpen the rigors of psychiatric and other drug research ~~-- which seldom includes children~~. Like many of you, the President has always been concerned that drug companies don't sufficiently test whether medicines are safe and effective for children. And just last week -- the Food and Drug Administration issued ground breaking new rules that require drug companies to conduct much wider testing of drugs in children. For too long, doctors have had little guidance in how to administer drugs to children and adolescents. And for too long, children have not been able to share in the recent progress being made in the area of drugs — including those that combat AIDS. I know that some of you here this evening have joined the President in this important effort — a cause for celebration for all of us who care about the health and well being of America's young people.

~~responsible~~ partnership

The children you help treat and guide today will be the next generation's leaders, elected officials, doctors, lawyers, educators, law enforcement officers; social workers; and perhaps most importantly — parents. Their future depends on the investments we make today: in early childhood development programs; in quality, affordable child care; in after school programs; in the expansion of programs like Head Start and Early Head Start; in health care coverage for children; in nutritional programs like WIC; in pre-and post-natal care for young mothers; and investments in Centers like this one — which will help ensure more hopeful futures for young people who are in trouble and in need of help — and which will help ensure that fewer children need these services in the first place. Those investments will yield great returns tomorrow -- in terms of increased prosperity, better health, fewer social ills, and ever-greater opportunities for our citizens.

As we approach a new millennium, and begin thinking about what gifts we can give to our children and future generations, let's rededicate ourselves to the promotion of children's well being in every domain — physical, social, intellectual and emotional. We are coming closer to the day when we can ensure that every child in American can fulfill his or her God-given potential -- free of pain and suffering, filled with confidence and hope, and ready to embrace the extraordinary challenges of the 21st century. With the hard work and dedication of people like yourselves — it's a goal we can -- and will — attain.

Thank you.

$1 billion across the board increase in NIH funding will have important implications for our children's research agenda -- from mental health research to research into how children learn to read to research into children with abnormal cognitive or mental health functioning to infant day-care research

important implications for drugs to treat child mental disorders -

New York State Psychiatric Institute
722 West 168th Street - Unit 78
New York, NY 10032

Department of Child Psychiatry

Phone: 212 543 5948

Fax #: 212 543 5966

Fax Cover Sheet

Date: 11/30/98

To: Nicole Rabiner

202 456-2878

From: David Shaffer, MD

Number of pages including this cover sheet: 8

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Comments:

COLUMBIA UNIVERSITY
COLLEGE OF PHYSICIANS & SURGEONS
DEPARTMENT OF PSYCHIATRY

November 30, 1998

Nicole Rabiner
Office of the First Lady
The White House
FAX#: 202 456 2878

I am attaching some graphs taken from the latest Centers for Disease Control, Youth Risk Behavior Survey. You will see that the trends for sexual activity among White and Hispanic groups are improving at more or less the same rate. The changes in the African American group are different, after a sharp initial improvement, changes have slowed down and are actually deteriorating with respect to number of partners and condom use.

The data I had discussed with Mrs. Clinton were suicide-related where Hispanic kids have a significantly higher rate of suicide attempts than other ethnic groups (twice as high as Whites for medically serious attempts in 1995), although all showed an improvement in 1997.

Glad to be of help.

Laura Kann
Chief of surv. research
CDC
770-488-3202

Yours Sincerely,

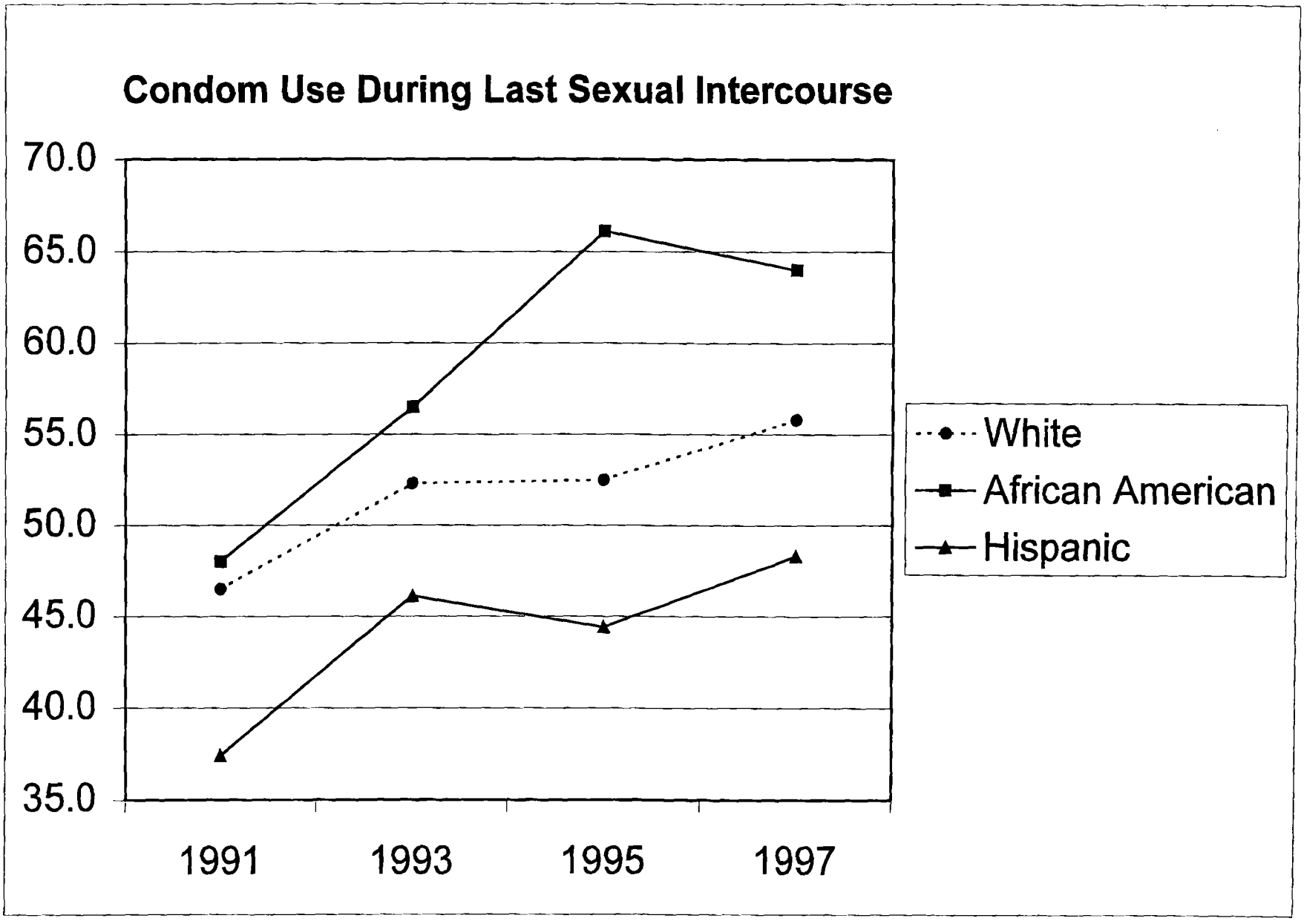
David Shaffer, F.R.C.P. (Lond), F.R.C. Psych. (Lond)
Irving Philips Professor of Child Psychiatry
Professor of Psychiatry and Pediatrics
Director, Division of Child and Adolescent Psychiatry

DS/dcr

Youth Risk Behavior study

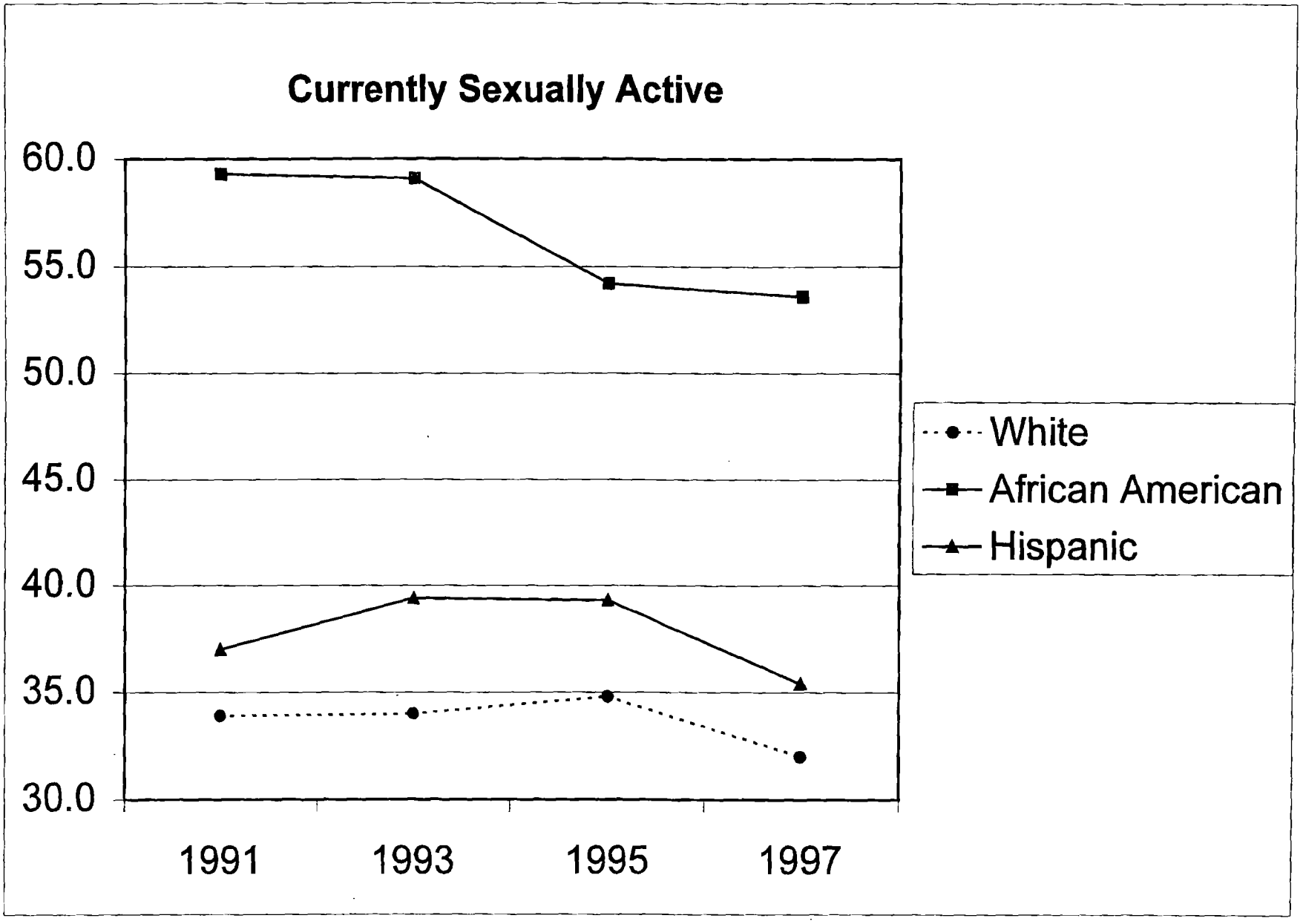
DIVISION OF CHILD PSYCHIATRY
722 West 168th Street New York, NY 10032 212-543-5948 Fax 212-543-5966

Percentage of High School Students who Reported Sexual Risk Behaviors



Youth Risk Behavior Surveillance, United States, 1997, Department of Health and Human Services: Division of Adolescent and School Health

Percentage of High School Students who Reported Sexual Risk Behaviors



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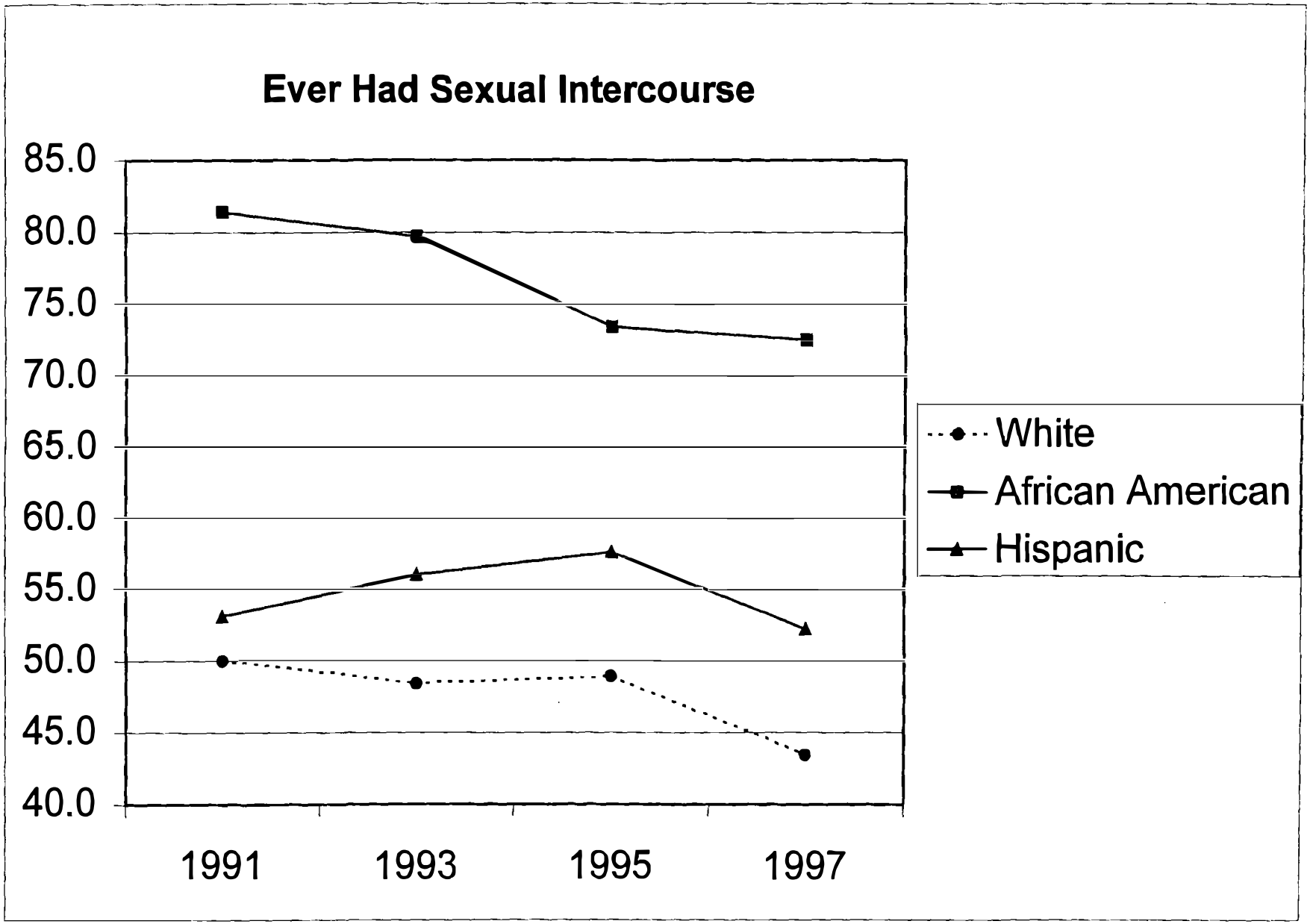

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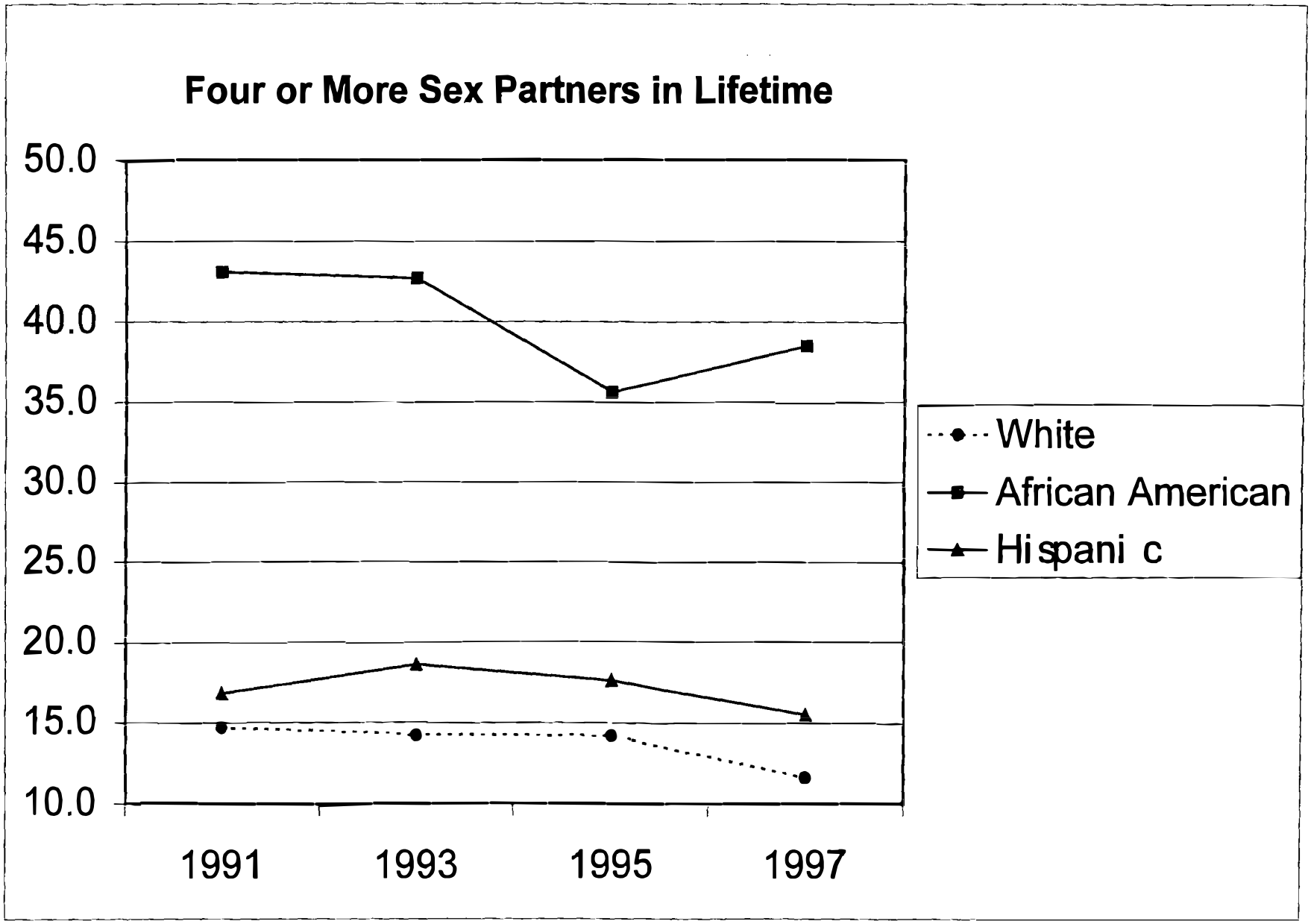
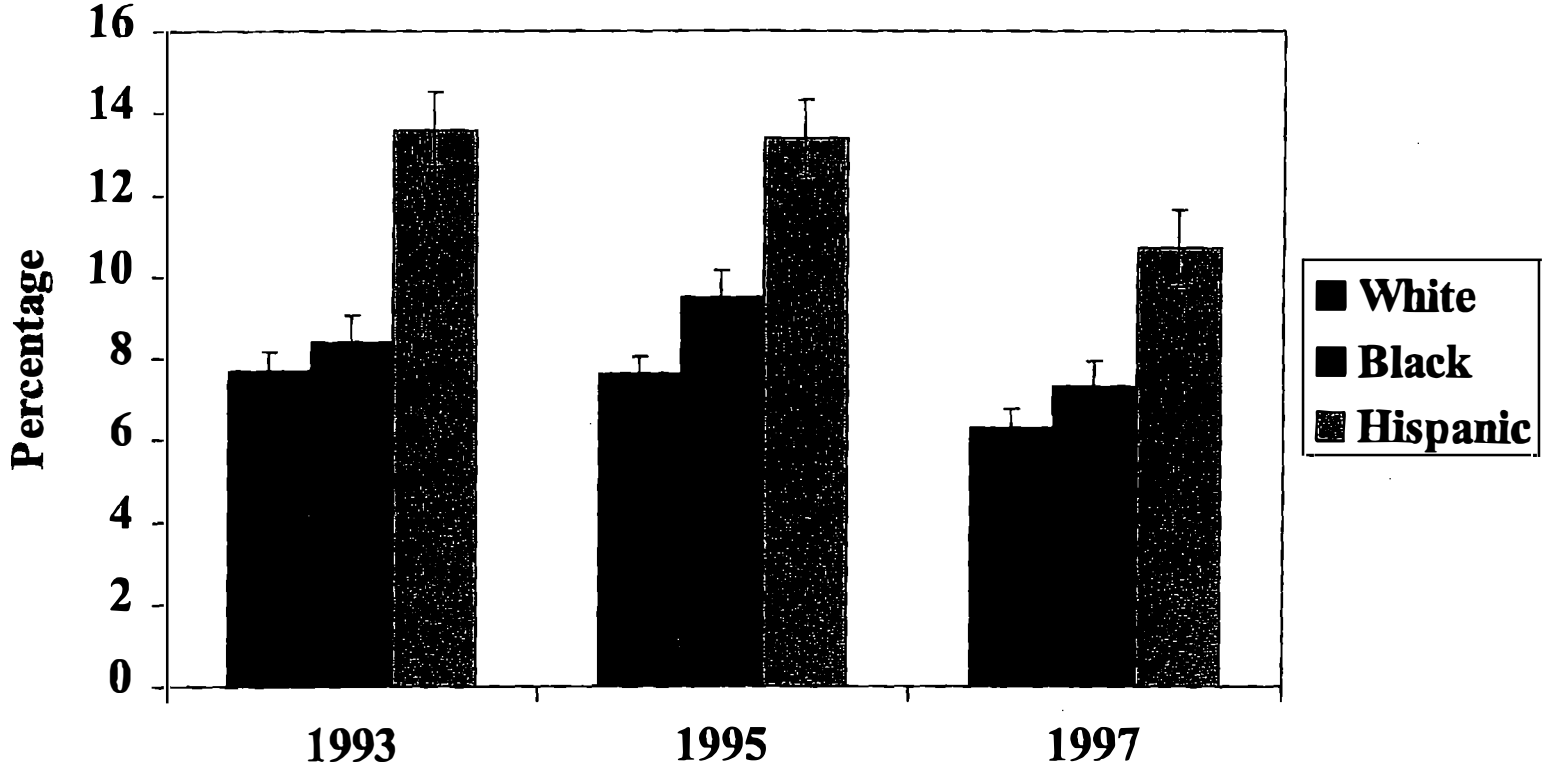


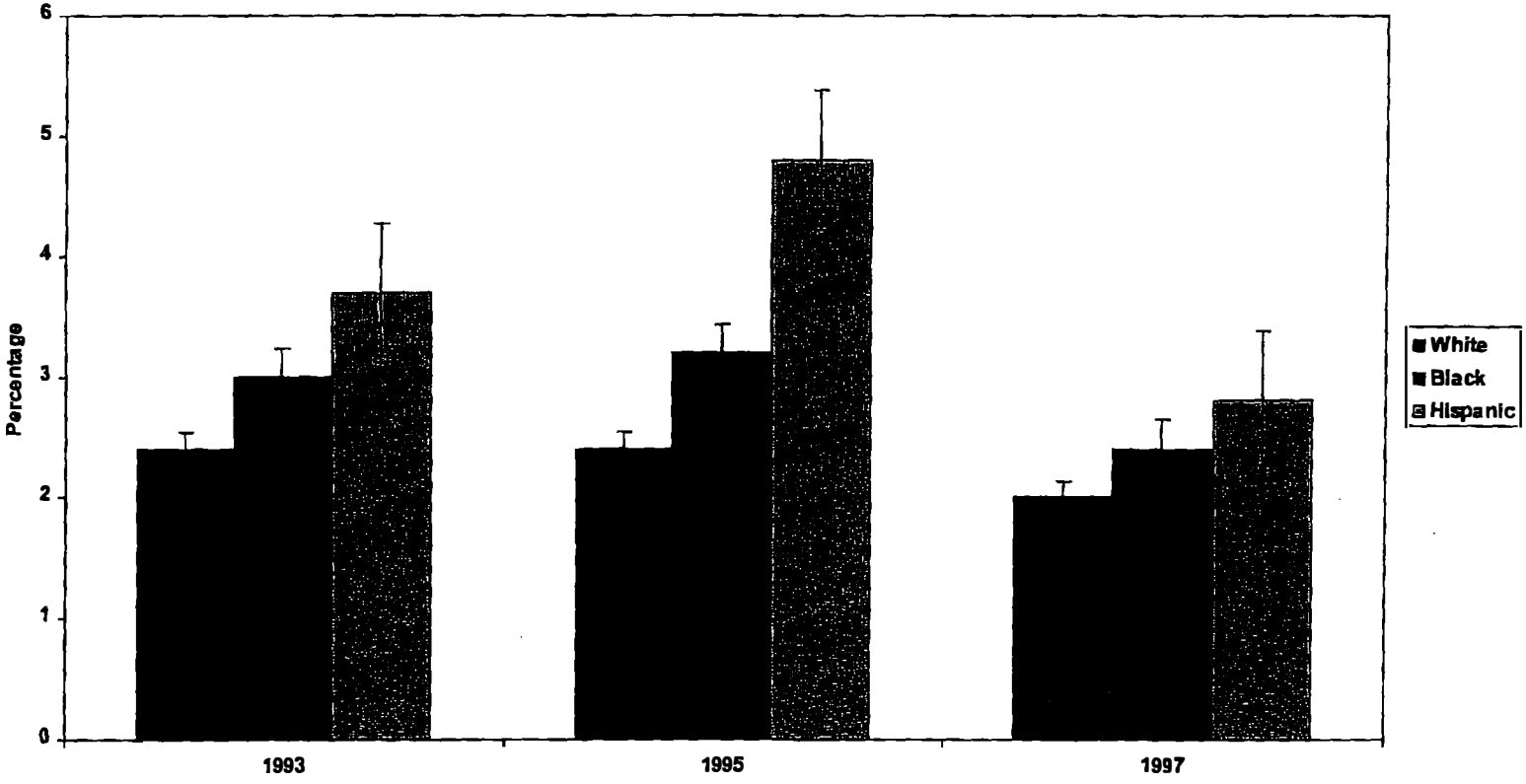
Youth Risk Behavior Surveillance, United States, 1997, Department of Health and Human Services: Division of Adolescent and School Health

Percentage of high school students who attempted suicide (N=16,260)



Youth Risk Behavior Surveillance System --MMWR

Percentage of high school students who made a suicide attempt which required medical attention (N=16,260)



Youth Risk Behavior Surveillance System --MMWR