

Slate

FAMILY

I Think I'm Worried About My Kid

Does my child need professional help?

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At the end of our last article, "[The Messy Room Dilemma](#)," which was about deciding when to let an unwanted behavior slide and when to correct it, we promised to consider a related question: How do you decide whether to seek professional help in dealing with a child's misbehavior? Families come to the [Yale Parenting Center and Child Conduct Clinic](#) because they were referred by a school official or a pediatrician, because Family Services or a judge ordered them to, or because the parents decided on their own that they needed help managing their children's behavior. Even if parents are inclined to let a problem fade away on its own, and even if it's likely to, they're not always in a position to wait for nature to take its course. And once they decide—or have it decided for them—to do something to correct a problem, they may well find that they need help.

What sort of advice can we offer to parents who find themselves confronting the question of whether to seek professional help?

First, context is crucial, and the most obvious context is the age of the child. Shoplifting a candy bar, for instance, can mean very different things when the culprit is 4 and when he's 14.

One complexity in evaluating children's behavior is that they're changing so fast, presenting a moving target for your judgments about the relative seriousness of their problems. Still, judging behavior is, in practice, usually a matter of judging behavior in relation to the child's age. For example, not being toilet trained by age 5 is not a psychological calamity or even a problem, except that parents are understandably sick of changing diapers. More specifically, for children of 5 and under, bedwetting is not very significant in relation to current or future adjustment, but after the age of 10 it becomes a risk factor that may presage serious psychological problems. It's the same behavior, but the age changes its meaning. Not being fully toilet trained by 10 or 12 predicts later aggression. The same is true of fears—of darkness, monsters, separation from a parent—all of which are a normal part of development for most children, even when those fears really do bother them. But the fears usually go away on their own. If they don't, the same fear in middle or later childhood (10 to 12) could signify a more serious anxiety disorder.

There are other kinds of context beyond age, like the family's need for a child to function well in a particular setting. A toddler who takes a poke at another isn't really doing anything very

worrisome, but if she does it one time too many and gets kicked out of the one affordable day care center in the neighborhood, then it can turn into a major problem for her working parents. While her behavior may not be a serious problem in the long run—preschool pugilism may well be a temporary phase she naturally outgrows—it's a problem in the context of her family's working and domestic lives, and so it may well have to be dealt with. The decision-making principle at work here is usually called "impairment." Does the child's behavior interfere with meeting the usual role expectations at home or at school? Many children have anxiety, fears, and tantrums, for instance, but does the problem interfere with going to school regularly?

Then there's historical context. A therapist in Alan's clinic had clients whose son made a YouTube video in which he playacted shooting his friends to death in a cursing rage after losing a board game. The parents wanted to focus on getting their son to complete his homework and clean his room, but the therapist told them that she was more concerned about the threat of violence in the video. They didn't share the therapist's alarm, and you might not, either. Boys, emulating the models provided by the world's movie industries, have been making violent home movies for as long as the technology has been available to them. What's the big deal? But the post-Columbine context changes the meaning of the behavior. For one thing, the string of school shootings in the past decade has made us more alert to rehearsing violence with peers as a danger sign; for another, it's easier now than it was in previous generations for a child to lay hands on the gun that allows him to turn the fantasy into reality. And even if you, the parent, still think the video is just harmless play, the other factor to bear in mind is that others *will* be alarmed. If neighbors and school officials get a look at it on YouTube, and they probably will, the prevailing ethos of zero tolerance ensures that your child's life and your own life are going to grow a lot more complicated in unwelcome ways. For all those reasons, it's not overreacting to deal with that behavior now—on your own terms, before you're forced to by drastic official acts like expulsion from school or mandatory referral to treatment.

So, a third principle: Danger and risk of danger. Is the child's behavior dangerous to himself or to others? This may involve aggressive behavior that could hurt others or self-injury. That's clear enough, but what if it's just talk? A child talking about killing himself or others must be taken seriously. The statements alone serve as a basis for seeking help or intervention. We're not saying that you have to haul your 4-year-old to the emergency room because he mimics a cartoon character saying "I could just die." Context matters, as usual. A young child may make an isolated statement or two, but the child seems fine at home, at school, and when playing with friends, and the statements disappear after a couple of days. That's one kind of context, and it would argue for just keeping an ear out for further statements. Another kind of reassuring context can be found in the minuscule suicide rate among the very young. But suicide attempts and suicide run in families, so that's part of the context, too, and it argues for alertness. And if a 12-year-old girl says the same thing, that's different. The suicide attempt and depression rates increase sharply with the onset of adolescence, especially for girls. Other context variables—not being involved with peers at school, the presence of a gun in the home, a "contagious" event in the media (a celebrity's recent suicide, for instance) that might inspire imitation—make the statement gain in seriousness until it's clear that you need to seek help for her. Danger to oneself or others is a special case in which you should err on the side of obtaining an evaluation. When in doubt, get a professional opinion.

This is tricky ground. You don't want to overreact to a possibility that remains unlikely, and very

low-rate events are difficult to manage. The likelihood of something terrible happening may be very low, but the magnitude of the event, if it were to happen, is so huge that one must consider intervening. It's easy to misdiagnose or overdiagnose the everyday problems of children (e.g., anxiety, depression, hyperactivity), but a professional can be especially useful here if he or she uses systematic measures to assess child functioning and danger. Getting such a professional opinion will either allay worries or speed entrance into a program that can make a change.

Another factor to take into account is that parents, teachers, and other adults tend to detect and respond to a child's externalizing problems—those that disrupt the environment, such as oppositional, aggressive, and anti-social behavior—more readily than to internalizing ones like depression and anxiety. The most common clinical concern in psychiatry and psychology raised by this tendency is the overdiagnosis of hyperactivity. It's easy to point to an active boy and say, "That child is hyperactive. Go get treatment and start medicating." Systematic ways of measuring behavior reveal that many such children do not meet the criteria for the diagnosis.

So pay special attention to what might be outward signs of internalizing problems.

First, has there been any change in behavior? A behavior may take on significance and become a problem because it represents a break from the usual pattern. Two different preadolescents might mope, tend to stay in their room, and not want to be with friends. This may be pretty much how one child acts and has always acted, which is also, by the way, kind of like the way his dad acts. For the other child, who is usually actively involved in things and pretty cheerful (when not giving the usual attitude, of course), moping and standoffishness mark a notable change. In the case of this latter child, a parent should be more alert to the possibility of depression. The change marks the behavior as clearly not a matter of temperament or enduring personality style but as something else.

Second, is the child showing signs of stress that coincide with exposure to an event or stressor? Here I'm talking about, for instance, exposure to a disaster (anything from the grand scale, like a hurricane, down to something in the household, like a fire), domestic violence, death of a relative, peer bullying, sexual abuse, or even exposure to violent TV, be it *CSI* or news footage. The child may show lack of sleep, nightmares, anxiety, clinginess, or impairment as noted above. Many of the effects are transient, depending on the child and the nature of the event. If they do not go away or lessen after a few weeks (depending on the child and severity of the exposure to the event), consider seeking help.

When in doubt, pediatricians, psychologists, and child psychiatrists are the first line of inquiry about how a child is doing. Pediatricians do not specialize in social, emotional, or behavioral problems and psychiatric disorders; their primary training is in medicine and physical health. But a large percentage of children (up to 40 percent) who are brought to them have psychological problems. Thus, pediatricians very often serve as parents' first contact with specialists who can treat such problems or make referrals to mental health professionals. Psychologists and child psychiatrists are trained to provide systematic evaluation, meaning that they use various standard psychological measures to see how the child is doing in many areas of social, emotional, cognitive, and behavioral functioning. And they're trained to look at different contexts—how the child is doing at home, in school, in peer relations—and assess any signs of trouble requiring follow-up.

In a subsequent piece, we'll talk about the next logical step in this process: how to decide on the approach and the particular professionals best suited to helping your child. You need to be a critical consumer of mental-health services, as critical as you'd be when buying a car or a house, and we'll offer some suggestions about how to equip yourself to face that challenge.

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