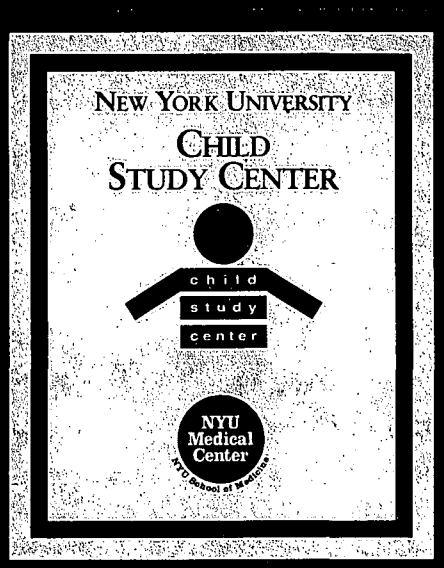
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Healthcare Today

NYU's Child Study Center: A National Resource for Research and Training

The New Child Study Center offers complete, expert psychiatric services for children and adolescents. Its emphasis is on early diagnosis and intervention

A unique Child Study Center, dedicated to advancing the understanding and treatment of child and adolescent mental health, has been established at NYU School of Medicine—the first program in New York to offer a comprehensive psychiatric program for children and their families.

The Center, which opened its doors in March, expands the current Division of Child and Adolescent Psychiatry and brings together experts in the field of child mental health and education to provide research, training and state-and-art patient care.

"We are so much more than a clinical program," said Harold S. Koplewicz, M.D., Professor and Vice Chairman of the Department of Psychiatry and Director of the Child Study Center. "By setting up a center that fully integrates patient care, research and education, NYU has within its reach the opportunity to define new standards in children's mental health—and become the nation's premier institution for child and adolescent care."

Dr. Koplewicz, author of *It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents,* is widely regarded as one of the nation's top child and adolescent psychiatrists and a nationally recognized authority on the psychological problems of American children.

"This is the first institution in New York dedicated to child mental health," said Dr. Koplewicz. "Given that about 12 percent of the population is suffering from childhood or adolescent psychiatric illness—almost 8 million American children and teenagers—it's fitting and appropriate that NYU develop a system that provides comprehensive clinical, research and training services."

He estimates that about 160,000 of New York City's 1.3 million school-age children and adolescents are in need of psychiatric treatment. "For far too many children," Dr. Koplewicz said, "lack of available care means a loss of childhood and an adulthood at risk."

Dr. Koplewicz and his staff have spent the last year carefully nurturing the Child Study Center's three-part mission: patient care, education and research. These vital components are incorporated through three main divisions:

• **Clinical Care** This program delivers all levels of patient care, from preventive care to outpatient programs to hospitalization. Clinical services are delivered through *Institutes of Excellence*, staffed by experts in various areas of mental health.

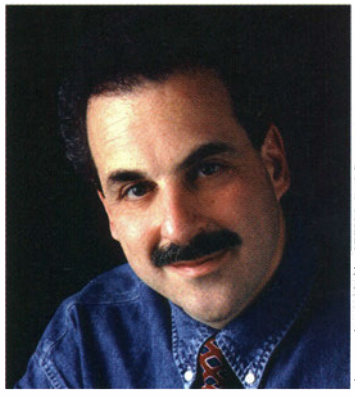
The Center's early efforts established the Attention Deficit/Hyperactivity Disorders Service, which includes evaluation, diagnosis and treatment for children, adolescents and adults with ADHD. The program provides social skills training and medication, as well as parent support and education. It also offers a free clinical medication trial and the *NYU Summer Program for Kids*—an 8-week therapeutic program for children with ADHD and their families.

Another important area for the Center is treating childhood anxiety disorders, such as separation anxiety and social phobia, common childhood problems. The Center is conducting several clinical trials that involve the testing of promising new medications for these disorders. (see box below)

Other services include the Infancy and Early Childhood Development Program, which evaluates and treats preschoolers with a wide range of difficulties, including developmental delays and behavioral problems. The Center has plans to establish several other *Institutes of Excellence* that will include programs for Tourette's syndrome, autism, learning and academic achievement, depression and eating disorders. It also is launching an inpatient program designed for college-age students requiring psychiatric care. "This group of 17 to 24 year olds—not quite adults but no longer children—is one that has been traditionally neglected by psychiatry," Dr. Koplewicz said.

• Another component, **The NYU-School Partnership**, pairs the Center's resources with public and private schools to focus on early detection and intervention for psychiatric problems in school children. "The focus of the program is preventive," said Glenn S. Hirsch, M.D., Deputy Director of the Child Study Center. "Children spend about one-third of their waking life in school, and it is there that psychiatric disorders often express themselves." The Partnership has an Educational Advisory Council of national leading educators and mental health professionals developing new models to address the needs of children and teenagers in school.

• **Parenting Institute** This third aspect of the Center is perhaps its most important one, particularly for identifying disorders and early intervention. "Just as parents are the child's first line of defense against physical illness, so should they be with psychiatric conditions," Dr. Koplewicz said. "Too often, parents misinterpret, or miss altogether, the early warning signs." Lectures and courses offered throughout the metropolitan area will help parents recognize and cope with childhood mental health problems. A new program, *Getting a Good Start,* offers a course on normal development to all new parents of babies born at NYU.



photograph provided by NYU Medical Center

Harold S. Koplewicz, M.D.

Parenting Institute Seminars

Parenting the Learning Disabled Student
September 24 • 7:30 p.m.

Making School Work for Your Child
October 7 • 7:30 p.m.

Help: My Kids Won't Listen
October 14 • 7:30 p.m.

To register, call (212) 263-6622

Treating Children With Separation Anxiety

It is late September. Families have adapted to morning schedules, and kids to new classrooms. Everyone has finally settled in. Everyone, that is, except Josh, a 7 year old, who is sitting in his teacher's lap weeping. Ask Josh why he hurts and he will tell you, "I have my Monday-to-Friday stomachache."

September is the king of transition times. Many children experience some degree of anxiety as they adjust to a book-bag full of change. But a child older than 4 who has not adjusted well within two weeks of being back at school may be suffering from separation anxiety disorder.

"Some refer to this syndrome as 'school phobia,'" said Dr. Harold Koplewicz, Director of the Child Study Center. "That term, however, is not accurate. Josh wasn't afraid of school; if his mom sat by his side all day, school would be fine."

Josh's stomachache is a classic symptom of separation anxiety disorder.

"Children like Josh can't concentrate on schoolwork and have physical complaints when nothing is physically wrong with them. Children with this disorder cannot be consoled and never seem to adjust to separation," noted Dr. Koplewicz.

Mental health experts believe that separation anxiety disorder has a genetic component, that is, it tends to run in families with histories of panic attacks. Research suggests that there also may be a physical explanation. It's possible that the brain malfunctions and releases an "all-systems-alert" danger signal during times of anxiety or even when there's no danger at all.

The first line of treatment for separation anxiety disorder is behavioral therapy. "We set up goals with the child and parents and reward different levels of changed behavior," said Dr. Koplewicz. The Center estimates that 40 percent of the children respond to this counseling in just four weeks.

For some kids with separation anxiety disorder, counseling is not enough. "If a child does not significantly improve within a month, we often recommend medication," said Dr. Koplewicz. The Child Study Center is studying medications to correct the chemical imbalance that may take place in the brain of a child with separation anxiety disorder, social phobia, and generalized anxiety disorder.

The outlook is promising. "We can't yet say for sure, and we're still investigating, but our strong hunch is that we can change the prognosis for these kids," said Dr. Howard Abikoff, Director of Research at the Child Study Center. "We believe that proper treatment may not only make their childhood easier, but will also make them happier, healthier adults."

For more information about the Child Study Center, please call (212) 263-6622.

Free Medication and Treatment for Volunteers

The Child Study Center at NYU School of Medicine has received a grant from the National Institute of Mental Health to study and evaluate the effectiveness of certain medications on children with anxiety disorders. Symptoms include: excessive worrying, being overly shy or anxious and fear of going to school. If your child is between the ages of 7 and 17 and has an anxiety disorder, he or she may be eligible to receive free treatment and medication from the Center. **Call (212) 263-7779 for more information.**

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ParentCorps

Program Goals

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Rationale

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 at every socioeconomic level feel isolated and overwhelmed.

As the world becomes more complicated, parents are given 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?; "What kind of rules should I set up at home and how do I get my child to follow them?"; "I don't want to hit my child. Is there any other way to get him to do what I want?"); ***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?"; "Is my daughter in right kind of classroom?"; "How can I talk with other parents in my child's school?"); and ***Finding Information and Resources*** (e.g., How do I find out if my child is depressed or just moody?; What kind of educational program does my child need?; 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?").

Research from various disciplines shows that parenting is one of the key predictors of problems in youth, including delinquency and antisocial behavior, substance abuse, depression, academic underachievement, school dropout, suicide and early pregnancy. 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. These promising findings are crucial to developing programs that will truly affect the lives of children and their families. Unfortunately, this important information 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.

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. Clearly, 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 behavior and academic problems, and for building healthy and strong communities.

ParentCorps aims to meet these needs by providing a systematic program for developing and monitoring parent-to-parent networks that actively engage parents to be more knowledgeable, confident, and effective in their important role of raising the next generation.

Overview of ParentCorps

We propose a five-year demonstration project to be implemented in four communities in New York City. If the demonstration project is successful, the program will be expanded to communities across the country. The ultimate goal of ParentCorps is to be a national service program, supported at the local, state and national level, dedicated to strengthening families and communities by training and supporting parent leaders, and creating parent-to-parent networks across the country. ParentCorps is based on the premise that training parents of young children, ages 3-8, in childrearing and parent-school communication skills, and facilitating parents' access to community resources, will foster the socioemotional, behavioral and cognitive development of their children.

ParentCorps Services

Services offered by ParentCorps include:

- **Parenting Skills Groups**

  Parent leaders will conduct 12-week Parenting skills groups at neighborhood sites covering the following topics:

  How to play with your child
  Using praise and encouragement
  Handling Misbehavior
  Using nonphysical consequences for misbehavior
  Strategies for community building
  How to help your child learn
  Effective limit-setting
  Using "time out"
  Strategies for working with teachers/schools

- **Parenting Workshops**

  Parent leaders will identify topics of interest to the community and will invite experts in the field of interest.

- **Parenting Helplines**

  Parent leaders will answer specific questions, provide technical support and problem-solving strategies, and help parents to access necessary referrals and community resources.

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  The ParentCorps Website will provide general information on parenting and community-specific information on resources and services. ParentCorps computer terminals will be set up in designated community organizations (e.g., schools, libraries, head start), allowing access for parents without home computers. Parent leaders will train parents on how to use the Website. In addition, parent leaders will contribute to the content of the Website by identifying community resources and updating information as needed.

ParentCorps Parent R.E.P.s

Parents with a demonstrated history of community involvement will be trained to become Parent R.E.P.s serving as Resources, Educators and Partners for parents in their own communities.

- Parent R.E.P. as Resource

A Parent R.E.P. has access to essential parenting resources in the community. The Parent R.E.P. knows what resources are available and how to access them. S/he facilitates referrals to appropriate child health, mental health, recreational, and educational resources within the community. The Parent R.E.P. helps in the development of a ParentCorps Website, which contains information about and links to community resources. The Parent R.E.P. informs parents about the Website and teaches parents how to access it and use the site.

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A Parent R.E.P is well-informed about child development, effective discipline strategies, communication and problem-solving, issues in child mental health and education. The Parent R.E.P works to strengthen the parents' knowledge base and understanding of child development, and improve parents' confidence with regard to implementing effective parenting strategies. The Parent R.E.P. does not impose his/her own goals on parents. Rather, goals are selected by parents with the help of the Parent R.E.P. who is aware of the family's own values, customs and beliefs. The Parent R.E.P helps parents generate solutions based on the circumstances of their own family and community.

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The NYU Child Study Center will oversee all aspects of program development, supervision and training, program evaluation and dissemination. The faculty 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 Parenting Institute provide 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 in an excellent position to develop, administrate, evaluate and disseminate the program.

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Prior to program initiation, we will develop an external Expert Advisory Board. 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.

Standardization

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

Program Evaluation

To help realize the stated mission of the ParentCorps, the program will be evaluated in three domains. The first is to confirm that the Parent R.E.P.s have successfully mastered the training curriculum, and that they maintain the integrity of the ParentCorps program as they work with families in the community. These assessments will entail formal testing of Parent R.E.P.'s knowledge of key concepts, their use of a collaborative model in working with parents in the community, and their ability to carry out program services as specifically described in the ParentCorps program manual. The second is to evaluate the effectiveness of the ParentCorps program. That is, we will examine whether Parent R.E.P.s' activities lead to meaningful changes in the lives of parents and children. Various procedures will be used to make these determinations, including: collection of "consumer satisfaction" evaluations from parents who have received assistance from Parent R.E.P.s (e.g., "How useful was the information provided by the Parent R.E.P.?", "Would you turn to a Parent R.E.P. again for assistance?", "Would you recommend the Parent R.E.P.s to a friend?"); comparison of relevant records from schools in matched communities similar to the selected ParentCorps communities, including school attendance records, and information about teacher-parent contacts (number, quality, person initiating contact, reason for contact); and inspection of the number of "hits" at the ParentCorps Website, which will contain relevant information about important community resources (name, address, phone number, contact person(s), services provided, etc.). The third area of assessment is to evaluate the degree to which the communities "take ownership" of the program. This aspect of evaluation will assess the involvement of community organizations in the ParentCorps program, including identification and selection of Parent R.E.P.s, efforts toward establishing positions for Parent R.E.P.s in the community, and provision of local funding for the program after the completion of the demonstration project.

for Nina Sander

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NYU Medical Center
NYU School of Medicine

CHILD Study Center LETTER

VOLUME 1 NUMBER 1 JANUARY/FEBRUARY 1997

Editor's Comment

We have changed our name! Our new name is **The NYU Child Study Center Letter.** The name inaugurates the first phase of The Child Study Center which now offers the following outpatient services: The Attention-Deficit/Hyperactivity (ADHD) Service of New York, The Parenting Institute and the NYU Summer Program for Kids, a day program for children with Attention-Deficit/Hyperactivity. Further description of these programs appears in the accompanying insert.

In this issue of the NYU Child Study Center Letter, Dr. Gabrielle Carlson reviews the latest controversy over the increase in the diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD).

HSK

ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER

HOAX OR HANDICAP ?

"Today the world is no longer safe for boys. A boy being a shade too boyish risks finding himself under the scrutiny of parents, teachers, guidance counselors, child therapists, all of them on the watch for early glimmerings of a medical syndrome (ADHD)...woe to the boy who combines misconduct with rotten grades; he is the likeliest of all to fall under professional observation...a generation or two ago, a guy with a learning disability—or an ornery temperament—-could drop out of school, pick up a trade and become, say, the best bridge builder in town. Now, if a guy can't manage to finish college, (he is out of luck)".

Natalie Angier, *New York Times 7/24/94*

Are mental health professionals, overzealous parents, and beleaguered educators taking the "boy" out of boyhood? Could a bridge in (not to) the 21st century be built by adults who have or had ADHD? The question is clearly not trivial. Educational administrators, teachers, guidance counselors and primary care physicians are in positions to make important decisions that profoundly affect the educational and emotional life for somewhere between 5-10% of school children.

Four concepts will help clarify this issue.

Concept #1: There are essential symptoms or criteria that comprise the disorder which has come to be known as ADHD.

These symptoms make up the acronym H-I-D-E. The H is for Hyperactivity, the I for Impulsivity, the D for Distractibility or short attention span, and the E for emotionality or low frustration tolerance. (The last, while not one of the essential criteria, is an associated symptom which frequently leads to psychiatric referral.) By establishing a set of symptoms about which there is general agreement, and which can be more or less defined, we increase the likelihood that we are talking about the same group of children.

Concept #2: This disorder or problem was not invented in the 1990s to sell Ritalin or to bankrupt school districts.

The disorder was identified as a pathological state almost 100 years ago, by G. Still, a pediatrician, who described a condition, more common among boys, as a "defect in moral control." The symptoms were hyperactivity, learning difficulties, attention problems, and poor conduct. A few decades later, with the pandemic of encephalitis lethargica, child victims were recognized as having very similar behaviors. These were felt to be due to brain damage and when, in the late 1930s, it was recognized that these problems could be treated with the stimulant Benzedrine, the concept of Minimal Brain Dysfunction came into use.

By the 1960s the terms "maturational lag" and "developmental hyperactivity" were coined, acknowledging that symptoms of the disorder change over time.

Unfortunately, with that came the notion that children outgrow the disorder. If one focuses on the most obvious symptom of hyperactivity, there does seem to be a change with age. Thus, for a decade or two, the disorder was called Hyperactive Child Syndrome, or Hyperkinetic Reaction, the official American Psychiatric Association designation.

Follow-up studies begun in the 1970s scuttled that notion. By the late 1970s research was coalescing around the observation that activity level fluctuates, but attention problems are a persistent deficit that lasts into adolescence and later — hence the term Attention Deficit Disorder. The 1980 nomenclature delineated by the Diagnostic and Statistical Manual III, (DSM III) operationalized the disorder and was followed by an explosion of research which tried to identify the nature of the attention deficit as well as to further refine the characteristics, outcome and treatment of the disorder. The current thinking is that we can identify a group of children that are relatively similar in their clinical presentation, outcome and treatment response. The current DSM IV criteria are not iron-clad, however. With each shift in terminology, we gather more information and improve our ability to identify, refine, and hopefully treat and prevent the condition.

Concept #3: The symptoms that comprise ADHD are "distributed" in the population

There is a spectrum of activity level, attention level, impulse control and emotionality. Some people need a bomb planted under them to effect movement: others are "hyper" but not necessarily destructively so. The controversy about whether we are identifying "exuberant" boys or "deviant" boys has, in part, to do with where the threshold is set. This is one of the reasons that standardized rating scales have become important. They try to compare a particular child against a standard of how their age and sex matched peers act.

Concept #4: A number of circumstances affect the manifestations of hyperactive and/or inattentive behaviors.

Even a normal child has trouble attending to a boring teacher, but he/she can manage. A youngster with mild/moderate ADHD will look almost normal with a very good teacher, but will look deviant with a poor teacher, and probably somewhat deviant with an average teacher. A child with severe attentional problems will look deviant no matter where he/she is placed unless modifications are made. The same thing can be said for the level of structure. In a well-structured classroom or family, normal and even mildly impaired youngsters will not stand out. As the structure breaks down, children at the borderline of normality will be pushed over the brink.

Is the ADHD problem getting worse, or are we all just supersensitized to it? It is important to examine what has changed in our schools and in our society that might be changing the manifestations of this disorder. The increase in the frequency of ADHD depending on the environment makes it no less of a disorder than well-known medical problems. For example, rates of diabetes declined dramatically during World War II or at other times of food shortage. When there is less food and less fat available, people eat less. Those on the threshold of abnormality will be normal in one circumstance and abnormal in another. Rates of asthma appear to be very different between urban and suburban populations and between rich and poor. The bottom line is that rates of ADHD may well be changing for a variety of reasons. That does not make the problem any less valid.

Keeping in mind symptom and environment interaction, it is important to delineate what constitutes a "disorder." The so-called "criteria" which have been publicized in checklists have evolved from research, clinical observation, and the consensus of experts trying to put together a set of standards which will identify children with problems without overidentifying normal ones.

HANDICAP ***is the concept central to the definition of a disorder. Does the constellation of symptoms and behaviors impair the child and produce a handicap?*** Is it like a ball and chain around the runner's foot that slows hm down and prevents him from competing in the race of life? Three important parts constitute the disorder.

1. The set of symptoms, which can be mild, moderate or severe.

2. The level of impairment and the persistence and pervasiveness of the symptoms. They must be observable in more than one place and must have lasted for a significant period of time. If there is no evidence that the symptoms began before age seven, the problem is not considered to be ADHD. Finally, the child must be impaired academically, socially, interpersonally, or in terms of daily family life.

3) Other problems that can account for inattention and hyperactivity must be ruled out. These include mental disorders such as depression and anxiety, learning and language disabilities, and certain medical and neurological disorders. In fact, many of these other disorders may co-exist with ADHD and need to be recognized for their own treatment.

With these concepts and definitions in mind, let us examine the premise that the children we identify as "too exuberant" and inattentive are just normal children. If that were the case, when we compare them to their peers, controlling for gender and socioeconomic status, we shouldn't see much difference. That is, if "boys will be boys," then the hyper ones shouldn't really be any different than the less hyper ones in important aspects of their lives.

School Performance

ADHD children are much more likely to have been retained or to access special education. Using a gross measure of academic achievement, the Wide Range Achievement Test, ADHD children show much higher rates of reading, spelling and math delays than the non-ADHD children. Part of the problem with these findings is that they don't control for IQ. That is, ADHD children usually have a lower verbal IQ than their peers, so it isn't surprising that their academic achievement is lower. However, when one looks at the IQ/achievement discrepancy, significantly more children with ADHD underachieve than non-ADHD children. That means that over and above the handicap in IQ that some children have with ADHD, there is an additional handicap. Many ADHD children have Porsche engines, but unfortunately their output is more like an old Dodge Dart. If you think about how frustrated you would feel having a high-powered car that won't go over 40 miles per hour, you might have some concept of what a non-learning disabled but ADHD child experiences.

Behavior Problems

Behavior problems are the nitty-gritty of the "boys will be boys" thesis. Unfortunately, ADHD boys, compared with controls, are much more likely to be truant, suspended or expelled from school. Up to 50% of children with ADHD have another disorder called Oppositional Defiant Disorder (meaning that, over and above their hyperactivity and inattention, they are argumentative, defiant, and volatile). Over one-quarter of a well-defined sample of ADHD youngsters followed into adolescence were found to have caused significant havoc in their school systems, compared to 8% of their non-ADHD peers.

Outcome

The most compelling evidence of how young people with ADHD differ from garden variety "boys" comes from outcome studies. At this point, several long term studies have been conducted with comparison groups of Non-ADHD children of similar age and SES. If we are dealing simply with boys with minor personality glitches to which school teachers and parents are said to overreact, then boys with ADHD should look pretty similar to boys without ADHD. That does not appear to be the case. Although it is true that we no longer see adolescents or adults who jump up on the furniture, open drawers of desks, or pick the bottom-most can out of the stack in the supermarket, we still continue to see higher rates of ADHD symptoms in by teenage years formerly hyperactive boys than in boys never diagnosed as hyperactive. In addition, the ADHD boys show significantly higher rates of frankly antisocial behavior, drug abuse, and mental illness in general, than "boys" in general. The good news is that there has been a substantial drop off in symptoms; in other words, if 40% of ADHD boys continue to have symptoms into adolescence, 60% do not feel they have problems that interfere with their functioning. However, that compares with 96% of non-ADHD boys.

By young adulthood, evaluating ADHD becomes much more complicated. Asking someone's employer to complete symptom checklists is generally not possible. However, even with methodological problems in mind, samples of ADHD boys show a further drop-off in serious behavior problems between adolescence and young adulthood. ADHD and antisocial behavior decline by half. However, almost 20% of the ADHD boys had engaged in criminal behavior, and, unfortunately, drug use problems persisted as did other mental disorders. Rather than being accused of taking the "boys" out of boyhood, one hopes that identification and treatment of ADHD

The NYU Summer Program For Kids

The NYU Child Study Center announces the establishment of the NYU Summer Program for Kids, the first summer day program geared specifically to the needs of **7 to12 year-old youngsters with Attention-Deficit/Hyperactivity Disorder (ADHD).** The NYU Summer Program for Kids will consist of an 8-week, all-day therapeutic program. The program is designed to improve children's

- Social behavior
- Friendship skills
- Academic competence
- Problem-solving skills
- Classroom behavior
- Sports competence
- Rule following
- Home behavior
- Anger control

Throughout the day all children participate in a full sports program, including swimming, as well as arts and crafts, computer, academic work and social skills training.

Children will be organized in age-appropriate groups of 12; each group is assigned 6 counselors and is supervised by a clinical psychologist. Licensed teachers conduct the academic, computer and arts and crafts classes and provide individual academic remediation when needed. Enrollment is limited to 36 children. This outstanding staff-to-child ratio enables the NYU Summer Program for Kids to make the summer a productive growth experience for each child.

Weekly specialized training for parents is an intregal part of the program and offers useful strategies for coping with problems at home and at school.

The NYU Summer Program is under the direction of Howard Abikoff, Ph.D., nationally renowned ADHD expert, Director of Research, NYU Child Study Center, at NYU School of Medicine.

The program is located in a school setting in Great Neck, Long Island, a 35-minute ride from Manhattan.

Tuition $7,000.00

Dates: June 30th through August 22nd, 1997

For further information about this specialized summer program call

(212) 263-6622

The Parenting Institute

Although schools and universities prepare us to become better lawyers, doctors, bakers and candlestick makers, they do not offer courses in parenting. To remedy this omission the NYU Child Study Center is proud to announce the establishment of *The Parenting Institute.* Through lectures and courses, parents will be helped to deal with the day-to-day challenges of raising children. They will learn to recognize the early warning signs of emotional problems and to distinguish between normal developmental issues and those that require professional intervention.

Parenting 101 will consist of a six-session course on enhancing parenting skills. small group workshops and single-session seminars will be conducted on topics such as:

- Parenting difficult infants and toddlers
- Raising responsible children
- Helping children reach their potential in school
- Managing families with two working parents
- Helping children with shyness and anxiety
- Sleep difficulties
- Dealing with the effects of divorce

For seminars and course offerings for winter and spring sessions, call:
(212) 263-6622

The Attention-Deficit/Hyperactivity (ADHD) Service of New York

ADHD is an illness that affects every aspect of an individual's functioning. Although it was generally believed that ADHD would be outgrown, we now know it often persists into adolescence and adulthood. ADHD can cripple a youngster's performance in school and seriously impair his or her social relationships. In adults it can impact negatively on career and marriage. For children, adolescents and adults, the *ADHD Service* will provide state-of-the-art diagnostic evaluations, treatment and special support groups to develop social skills, organizational abilities and parenting strategies.

For further information or to schedule an appointment for consultation, call:
(212) 263-6622

might, in fact, take the "hood" out of boyhood.

The educational toll on ADHD youth remains quite high. Follow-up studies show that significantly more ADHD youngsters than Non ADHD youngsters did not complete high school, and a significantly lower rate finished college. Data from studies of young adults seen in the 1980s and 1990s come from people who were born between 1958 and 1969. Therefore the toll on family life, marriage, job stability, etc. has yet to be determined. Most are working; a high number are self-employed. Incomes and occupational achievement, however, are still lower than their non-ADHD peers.

Summary

The early onset of a core group of symptoms that interferes with a child's functioning, has substantial, although not perfect, ability to predict the course of his/her development. Although the boundaries between how much exuberance is too much may be unclear, in its clearest forms, ADHD entails both a significant burden for the child and family, as well as long term impact. Like any handicap, it is not unsurmountable. However, it does impede the sufferer. It is an especially cruel hoax when those who are in a position to help ignore their responsibility or worse, decide that other people's suffering is trivial and artificial.

ABOUT THE AUTHOR

Gabrielle A. Carlson, M. D., has been Professor of Psychiatry and Pediatrics and Director of the Division of Child and Adolescent Psychiatry at the State University of New York at Stony Brook since 1985. A specialist in child and adolescent psychopharmacology, especially mood disorders, suicide and attention deficit disorders, Dr. Carlson has written over 80 papers and chapters and has co-authored two books, ***Affective Disorders in Childhood and Adolescence*** (Spectrum Publications) and ***Psychiatric Disorders in Children and Adolescents*** (W. B. Saunders). Dr. Carlson serves on the editorial boards of several professional journals, including the NYU Child Study Center Letter, and on numerous professional committees.

SUGGESTED FURTHER READINGS

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PIONEERS IN CHILD AND ADOLESCENT PSYCHIATRY

Howard Abikoff, Ph.D., formerly Associate Professor of Psychiatry at the Albert Einstein School of Medicine, has recently joined the faculty of the NYU School of Medicine as Director of Research in the Division of Child and Adolescent Psychiatry. He describes the move as an extension of his previous work as well as a new beginning. Included in his plans is the implementation of the results of his many avenues of research to the operation of the newly established ADHD Service at NYU.

Dr. Abikoff's career and accomplishments as a psychologist for the past twenty years have been interwoven with the burgeoning of research on Attention-Deficit/Hyperactivity Disorder, to which he has been a major contributor.

A consultant and reviewer to the National Institute of Mental Health, he has been an invited participant in numerous NIMH conferences regarding methodological design issues and treatment strategies for children with disruptive behavior disorders. He is a member of the Editorial Board of the Journal of Attention Deficits and a reviewer for numerous other journals.

Starting in 1973 at Hillside Hospital, Dr. Abikoff collaborated with Dr. Rachel Klein, (at present Professor of Psychiatry and Director of Psychological Services at Columbia University) on an NIMH grant comparing stimulants, behavior therapy and a combination of both in (then-called) Hyperkinetic Children. Their collaboration, continuing for the following 23 years, has resulted in numerous studies on issues such as the efficacy of stimulant medication and of psychosocial interventions with children with disruptive behavior problems. Dr. Klein, originally a mentor, has become a treasured colleague and friend.

The thrust of Dr. Abikoff's own work has been the development of evaluation and therapeutic strategies which serve as adjuncts to medication treatment in ADHD children. His special interest in understanding how ADHD is manifested in real-life settings has also resulted in the development of objective assessment instruments to be used by non-biased observers.

In reflecting on the course of the changes in the psychosocial treatment strategies employed to modify the impulsivity of many children with ADHD, Dr. Abikoff remarked on the evolution from the earlier treatment that used cognitive training approaches—a strategy not found to be useful—to the current treatment emphasis on behavioral approaches.

Dr. Abikoff views the current major challenges in the field of ADHD research as occurring on inter-related and multi-

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ple fronts, one of which entails research regarding the etiology of ADHD. He stated: "The next five to ten years will produce exciting results in the fields of molecular genetics and the neurosciences, perhaps in the identification of genes specific to ADHD or documentation of the differences in the dopamine receptors in ADHD children compared to normal children. Discoveries such as these could lead to advances in the design and refinement of treatment strategies."

Dr. Abikoff envisions that the answers to some key questions will be provided by the results of a NIMH-sponsored cooperative national and Canadian multi-site program, the Multimodal Treatment of ADHD (MTA) Study, in which he is a study designer and a participant. This study, involving approximately 600 children, is the largest clinical trial ever undertaken with children and compares the efficacy of four treatment approaches—medication alone, psychosocial intervention alone, a combination of treatments, and standard community treatment—delivered over a 14-month period. Preliminary results will be available in approximately one year; it is anticipated that results will clarify which of these treatments is most effective and which are most appropriate for children with ADHD who have co-existing problems, such as oppositionalism, depression, etc. According to Dr. Abikoff, "The results of this extensive study will have implications for public health policy, including the ways to integrate psychosocial and pharmacological services within school settings and within the family."

Among Dr. Abikoff's future research plans is continued work with youngsters with disruptive disorders and youngsters with internalizing disorders such as anxiety. He is also interested in investigating ways in which clinical research findings can influence the delivery of services in mental health settings.

CHILD STUDY CENTER

New York University Medical Center is building and developing a new Child Study Center which will expand its current Division of Child and Adolescent Psychiatry and will bring together experts in the field of child mental health and education to provide research, training and state-of-the-art patient care.

Upon its completion, the Child Study Center will provide a full range of integrated services. Outpatient programs will include subspecialties in a wide variety of psychiatric disorders including the Attention-Deficit/Hyperactivity Disorder Service of New York City. The Center will include partial hospitalization and inpatient programs and preventive services, including The Parenting Institute, the NYU-School Partnership and the Law and Psychiatry Program. For more information about the clinical programs of the Child Study Center please call (212) 263-6622

If you are interested in supporting the Child Study Center please contact Maggie Buchwald, Office of Development at (212) 263-5824.

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Editor's Comment

"Girls and boys enter school roughly equal" states the 1992 report, *How Schools Shortchange Girls*, issued by the American Association of University Women.[1] "Twelve years later, girls have fallen behind their male classmates in key areas such as higher-level mathematics..." and their self-esteem is especially vulnerable. By adolescence many girls suffer a staggering loss of confidence in themselves and develop critical attitudes towards their bodies. A lowering of self-esteem occurs also in adolescent boys, but not to the same degree as girls.

In this issue of the **NYU Child Study Center Letter**, we focus on gender differences in academic settings. We present the views expressed by a group of adolescents we interviewed on this topic as well as the most recent research.

HSK

GENDER DIFFERENCES IN ACADEMIC SETTINGS

Introduction

People learn about what society expects of them as men and women in a number of ways. The media project certain images, families foster other understandings of what it means to be male or female, and schools have their own ways of telling boys and girls what is expected of them. To explore the views of young people on these issues, the authors conducted a seminar with high school juniors and seniors, both boys and girls, who reacted to the following questions: In your experience, what messages have your schools and the media conveyed to you about being a boy or a girl? How do boys and girls develop a sense of what's appropriate behavior for their gender? How do teachers and other important adults at school and at home help or hinder young people in defining themselves, regardless of gender?

Following are excerpts from the group's comments.

NATURE OR NURTURE?
Are boys and girls born with inherent differences?

What did the teenagers say?

Manuel: I think a lot has to do with parents and society, because I know at least in my culture it's agreed that if a couple don't have a boy, it's "better luck next time." Boys are less social genetically. They're more aggressive and adversarial. That's just a natural thing.

Suellen: I have a brother in the lst grade and one in the 4th grade. My parents haven't exactly encouraged them to be cave men but inherently they grow up differently from the way I am. Girls dress up dolls and that's a very maternal thing to do. Boys make war. It's not how you raise them; it's how they are.

Nathan: When I helped out in a 5th grade classroom with a research project last month, all the guys picked bombs, war, nuclear explosions, and the girls picked things like the history of dolls. They're always interested in different things, even in kindergarten.

What does the research say?

Boys at an early age are more active and aggressive than girls, although this is obviously not true for all boys and girls. In terms of brain differences, preliminary studies by neuroimaging techniques, just beginning to be used on the brains of infants and children, show no gross anatomical differences.[2] The brain, however, is not a constant. It adapts and changes according to the environment, and from the very beginning of life girls and boys are treated differently at home, at school or at play. Infants, children and adults are constantly informed of what behavior and what personality traits are appropriate for their gender.

Children are quick to learn their place in the social scheme, and by the time they get to school they have already absorbed a set of beliefs.

Differing academic expectations begin as soon as children enter school, especially when the school is not sensitized to the need to provide equal opportunities to boys and girls. When adults are asked to picture an intelligent child, most visualize a boy. Particularly in math and science, parents consider boys to be more competent than girls.[3]

Children tell the gender story in their own words. Almost 1100 children were asked to write about what life would be like if they experienced a gender change. Forty-two percent of the girls responded positively to the idea of being a boy, stating that they would feel more secure and less worried about what people thought of them, would be treated with more respect, and would earn more money at better jobs. The percentages were strikingly different for boys. Ninety-five percent of the boys saw no advantage to being a girl.[4]

THE MEDIA INFLUENCE:
What images do they project about boys and girls?

What did the teenagers say?

Janet: I walk by the 8th grade classrooms and they have all these pictures up of models cut out of magazines; girls try and imitate that, for whatever reason.

Jon: The portrayal of women has been drawn attention to a lot of times; women don't have to be seen as docile servants who live in the house making dinner and dusting. But men still have to be the breadwinners, still have to be macho.

Elena: I think in the media, especially in television, there's a lot more emphasis placed on smart men as opposed to smart women. The emphasis is on how

you look if you're a woman and how intelligent you are if you're a man.

Josh: I think guys are just as pressured as girls, but we just don't accept it. You see just as many images of men as the perfect model of the way men should be; you just don't see men reacting to it.

What does the research say?

The power of the media is recognized in many spheres of development — in the fostering of attitudes, prejudices, the use of violence and in the development of one's self-understanding. It is not surprising, then, that the media help shape the views of today's teenagers about what it means to be successful and acceptable as a male or female. Themes of television programs, videos and movies duplicate sex-role stereotypes. Boys are seen in action and adventure shows, girls dominate game shows. Girls are twice as likely as boys to show affection, boys are more likely to use physical force. Women are less likely than men to work outside the home; in television dramas and sitcoms if women have a job, they are usually unmarried or divorced. Women are younger than the men and attractive, but they age quickly. Men have more high-status positions and they successfully combine outside employment and marriage.

THE DATING GAME: Is it different for boys and girls?

What did the teenagers say?

Janet: I don't think people go on a first date with somebody because they have a great mind. A lot of girls will go out with ugly guys just because they want a boyfriend. They don't know how to say no. Then they get a reputation for being a slut; a girl is called a slut and a guy is called a player.

Mark: In our peer group we wrote down what we find attractive in the opposite sex, and the guys wrote down flat out physical characteristics and the girls wrote down stuff like *charming, nice smile, sense of humor*. There was also *nice butt*, but there's less of that and more of abstract things.

What does the research say?

Although not specifically part of academic life, a strong interest in dating and romantic relationshps occupies the minds and time of many teenagers. Here, too, gender differences are manifest.

Girls as young as 12 report that they are preoccupied with their appearance and perceive appearance to be the determining factor in rejection or acceptance by their peer group.[5] The changes of puberty affect boys and girls in different ways. Height and muscular development are valued for boys and seen as evidence of a new masculinity, but for girls height, greater body fat, and especially breast development, signal sexuality.

MATH AND SCIENCE: Why more boys?

What did the teenagers say?

Jack: In my chemistry class there are less girls. I don't want to sound sexist, but it seems to me in the science classes the smarter people are the boys. I'm not saying they are, but it looks that way.

Adam: In my computer science class last year we had 8 boys and 6 girls. Now it's down to 7 boys and no girls.

What does the research say?

While the research on the levels of participation in advanced math and science demonstrates that boys appear more active and able, research on basic mathematical and spatial abilities shows equality among the sexes. We can only surmise that social factors intervene in the lives of girls as they proceed through school to hamper their mastery of these subjects.

Girls show a steep drop in their interest in math and science as they advance through school. Girls score as well as boys in math in the elementary school years, but fall behind in high school.[6] Confidence is the variable most strongly associated with achievement in math. In the elementary school years girls' attitudes toward math are much more positive than boys' attitudes, but by age 15 half as many girls as boys feel competent in math.[7] Since good math test performance depends on the number of math classes taken, the avoidance of math classes obviously results in lower standardized test scores in some cases.

In answer to an AAUW questionnaire, boys were more likely to say they're good at many things and to name their talents as what they like best about themselves. Girls usually named an aspect of their appearance and were more likely than boys to say they're not smart enough or not good enough.

In technology, a field related to math, girls show less interest than boys in using and learning about computers. Despite their equal competence in actual computer use, they report feeling less competent.[8]

In science, the achievement gap between girls and boys is actually widening: the National Assessment of Educational Progress found that, for thirteen-year-olds, gender differences in all areas of science performance except biology actually increased during the 1980s. By age seventeen 50 percent of boys but only 33 percent of girls can analyze and interpret scientific data.[9]

The general culture does little to encourage scientific competence in girls. Science is considered a masculine endeavor, and studies have shown that the enrollment and retention of women in undergraduate science and engineering classes is dependent on the affective climate prevailing in the school. as well as on the presence of female role models.[10]

It is important to note that gaps in science and math achievement are related not only to gender, but are also related to factors such as socioeconomic class, race and ethnicity.

Gifted girls appear to have even more difficulties in school than girls in general. Until about the fifth grade, gifted boys and gifted girls achieve about equally in school. After that time, fewer girls are identified as gifted.[11] Many gifted girls are uncomfortable with the gifted label, wishing to 'blend in.' Gifted girls, usually more socially adept than gifted boys, pick up social cues and know how to fit in. Giftedness and leadership often go hand in hand and, in boys, this quality is encouraged and they are described as leaders. In girls, however, leadership is often viewed as bossiness and is discouraged. Girls' groups demand conformity and may ostracize the girl who is a high achiever. She may not have many friends, receive fewer invitations to parties, and is sometimes made fun of. Gifted girls learn that it is smart not to look too smart.

IS DAILY CLASSROOM LIFE THE SAME FOR GIRLS AND BOYS?: Do teachers treat them differently?

What did the teenagers say?

Sue: The girls don't speak up as much; then the teachers don't call on them. The boys just shout out.

Ann: If that was happening to me I would be discouraged to put up my hand.

If all the boys were yelling out, I might stop raising my hand. I wouldn't pay attention; my grades would go down.

David: The guys ask better questions and stuff than the girls.

Arthur: Now teachers call on girls more; it's almost as though they're afraid to call on boys.

What does the research say?

Since becoming aware in the late 80s of how teacher behavior has inadvertently fostered old gender stereotypes, many schools have designed programs to sensitize their faculties and students to the need to give equal voice to all in the learning process.

After evaluating teachers in action in 100 classrooms in four states, researchers found that male students ask and answer more questions, receive more praise for the intellectual quality of their ideas and get more help when they are confused. Girls in schools receive less attention, both positive and negative, than boys as early as the daycare years. Teachers expect more from boys than from girls. In some studies boys were given more instructions towards completing tests and were spoken to in harsher tones than were girls. Girls often had their tasks completed for them and were spoken to in gentler tones. Boys call out in class eight times more than girls. After the grade school years, girls become reticent in expressing their ideas and opinions in school and many more boys than girls will argue with a teacher whom they believe to be in error.[4]

Although boys are favored in many ways by the educational system, they also have special problems. Boys are more likely to fail a course, miss promotion or drop out of school than girls. They receive more resources and attention, negative or positive, than girls. As the range of choices for girls has widened, stereotypes for male behavior are still in place – don't show emotion, be competitive, aggressive, compete and win.

Conclusions

Many changes have occurred over the past 20 years. More girls are taking advanced math and science courses and more women are enrolling in college and graduate schools. Parents, educators and students are working to establish gender equity in schools. Nevertheless, females still score lower on the Scholastic Aptitude Test, the College Board Achievement Tests, the Graduate Record Examination and other examinations critical for college and graduate school admission. Boys are more likely to be awarded state and national college scholarships. Most of these tests underpredict female performance and overpredict male performance, so multiple measures of ability and achievement should be used.[12]

While some of the gaps can be attributed to the fact that girls take fewer advanced science and math classes, behavioral differences and differing expectations also have a significant impact.

The teenagers we spoke with and the research reported demonstrate that some gains have been made in the quest to bring true gender equity into the lives of our children. On an intellectual level, all agree that equal opportunity and recognition are the goals we seek. What we observed on an emotional and experiential level is that in the lives of the fifteen teenagers with whom we spoke a gender gap continues to exist.

Schools and families have chosen to tackle the problem in a variety of ways. Some seek no change from the status quo, accepting differences as right and proper. Others choose single gender schools for their children, hoping that this will foster independence and the full use of talent, especially for girls. For many girls this choice brings the desired result. Still others choose to try to effect change by encouraging teacher training within coeducational environments, as well as special programs and efforts to foster gender equality for both boys and girls. All approaches have their merits and their limitations, but achieving equity in education must be given a higher priority. It has been shown that women's perception of themselves as second-class citizens contributes to their vulnerability to conditions such as eating disorders, anxiety and depression, all of which are more prevalent among women than men.

It is clear that we must keep at the task of bringing boys and girls, our men and women of the future, on to an even playing field, because we're certainly not there yet.

About the Authors

Sandra J. Theunick, Head of The Chapin School in New York City, has worked in independent education for the past thirty years, sixteen of them as School Head. She has a keen interest in the development of educational programs which will enable students to understand and overcome bias of all kinds, religious, racial or gender-based.

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