

ASSOCIATION OF FAMILY THERAPISTS

January OF NORTHERN CALIFORNIA 2007

PRESIDENT'S COLUMN

by Roger Lake, MFT



With this column, I'm passing the Presidency of AFTNC to my sagacious colleague, Terry Patterson, who will take that title at our next Council meeting in February of 2007. I've held this position for the last

two years, and feel privileged to have done so. I've also felt anxious, insecure, and at times overwhelmed, but always supported by the really good people who make up this Association.

While I have some developments to report in this column, what I really want to take note of is just how cool it is to have something like AFTNC to connect with in my professional life. In my experience, it is not the capacity that this organization has to deliver direct benefits to me (or any member) via training events, this Newsletter, our web site, the LIST SERV and so on, but rather the people I meet and work with. AFTNC really does represent something different from other professional organizations

in which I hold membership. It has always been the place I feel most at home and with family in the wider and sometimes alienating landscape of mental health work.

I had dinner a few weeks ago with Bill Pinsof, whose presentation at our Fall Conference is reviewed in this Newsletter. He was both frank and praiseworthy in saying how much fun he had with us, and what a truly unique group we have, with students and very senior practitioners together in such a relaxed atmosphere. That's how I feel about AFTNC. We are this really wonderful anachronism in a world that accepts family therapy as mainstream, but offers very little training and ongoing support for the majority of practitioners in our field who practice privately or in agency settings. It is this spirit that I have tried to serve, and will continue to evoke as I remain on the Council as Past-President.

The Council of this Association does, and must continue, to embody the spirit of family as the center of what we do. In the beginning, we were about the amazing explosion of freedom and creativity that Alan and Eva Leveton so marvelously reflected on two years ago in their Past Times presentation, a meeting that brought many old timers briefly out of the mist. By the

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time I came along, twenty years later, it was a collection of folks held together by shared commitments to family therapy and to the rituals of the Association, particularly the Fall Conference. The governance of the association has always depended on member participation, as we have chosen to avoid the problems (and benefits) of an administration paid for by member dues and/or fundraising efforts. Consequently, we get what we don't pay for — us. I have been privileged to work with council members who, bless them all, manage to carve time, resources, and a resilient sense of humor out of work and family lives that are every bit as demanding as anyone's who might be reading this now. I would name them, but they are already named in this publication, and recent ones, and (as a grandfather) I know not to voice favoritism, even when I feel it.

Because we have given up the pretense of elections, the Council is always in some form of transition. Terry follows me because he is a guy who can and will step up. I followed Robert-Jay Green because I knew it was my turn. Robert-Jay took over from Bart Rubin because somebody needed to. That's the way it's working right now, and I have no objections, other than to make note that Terry makes the third consecutive white boomer man who lives in San Francisco to head the Council. While that observation really fails to take account of the diversity on the Council itself, I think it should give the membership cause to question how this is working, and hope it encourages others to become more engaged in the work of the Association by volunteering to work on the Council.

To report on my time in this office, let me say that the most important development has been to grant membership to students, and to give them an expanded voice on the Council. Our student reps have been bright, earnest, and committed, and we have worked to establish a mentor program and representatives in all the local training programs. Students now represent a

solid block in AFTNC. We have also added a voice for people of color on the Council; by creating a position currently held by Erica Torres. In my view, we need to do more at the level of the membership to support and develop the experience of people of color in AFTNC, and I regret not having given that enough attention as President.

Our effort to establish a family therapy externship-training program in the Bay Area that was begun several years ago has proven difficult, and is not a current project of the Association. The faculty put in a great deal of hard work and learned a lot. I think that the training issue is extremely important to our general purpose as an association, and look to Terry's leadership and his experience as an educator to further this agenda.

The financial life of the Association continues to be modest but robust. We raised dues by twenty-five dollars in 2005, the first raise in over twenty years. We had a successful Fall Conference that, once again, covered our cost. Because we maintain an adequate reserve, the Council has chosen to invest some funds (a relatively small amount) in scholarships for the Annual Conference, and a more substantial sum in developing our web site and LIST SERV to make them more useful to ourselves and the communities we serve. I think that the membership will begin to notice this very soon, as the project is now underway. Shawn Giammattei, Ron Pilato, and Jay Seiff, who represent the new generation in AFTNC, awe me with their familiarity and expertise in tech stuff. I feel very confident in their ability to guide us through this project in a fiscally sound manner, and look forward to the results.

I leave office with a sense of relief and recommitment. My time in office has coincided with the slow passing of my Father, who died shortly before the Fall Conference. The time I had with him, my Mom, my siblings, our kids and grandkids, has been a blessing, but also time

consuming. My efforts to recruit members to the Council (which seems a very important part of this position) always surface the issue of family life cycle development. Family therapists (more so than other mental health workers) seem to have families. Families command our attention. That's a fact with which we all grapple. I continue to be grateful to the wonderful members of the Association, particularly those who've been on the Council these last several years for supporting and understanding me in ways that mean so much. I'm absolutely convinced that I didn't utilize the available resources in my Presidency, but hope to remedy that over the next several years. For me, this is just a welcome step out of the spotlight.

Roger Lake, MFT, is in private practice in San Francisco.

EDITOR'S COLUMN

by Michelle Mason, PhD

Just like families, AFTNC experiences changes as well. This issue of the newsletter reflects one of those periods of transition. While Roger Lake reflects on his experiences of AFTNC in the



“President’s Column,” we also have an introduction to our incoming President, Terry Patterson, through his article “I’ve seen the future...or was that the past?” Here Terry introduces us to some key issues he feels are important to keep in mind as we move forward.

Be sure not to miss the article on our upcoming AFTNC Event this February 11, at USF where Larry Diller, MD, will present information helpful from his new book *The Last Normal Child: Essays on the Intersection of Kids, Culture, and Psychiatric Drugs* (Praeger, 2006).

This event promises to be especially helpful to clinicians looking for ways to balance the trend towards diagnosing and medicating children for minor differences in behavior and performance. There will also be an AFTNC Mentor/Mentee Event immediately before Dr Diller’s presentation.

Cheryl Deaner gives us a “Report on the 43rd AFTNC Conference.” She not only captures the atmosphere of the conference, but does a great job summarizing Dr. Bill Pinsof’s work on Integrative Problem-Centered Couples Therapy. This article should be a pleasant review for those who attended and a great introduction for those who missed the Conference.

I would also like to thank Mary Cronin, not only for her wonderful work as the previous Newsletter Editor, but also for her mentoring, help, and guidance as I take on this new role. I was first introduced to AFTNC three years ago at the yearly conference when I became a student member. I will never forget the atmosphere of warmth and acceptance, the mix of stimulating ideas and conversation, and the experience of finding support as a “young” family therapist that I found there. It has been a joy to continue to have similar experiences each time I engage with this organization. This is why I agreed to take on the position as Editor.

Please feel free to contact me with any ideas or suggestions. If you have reactions to articles you’ve read which you’d like our members to hear, please send in a Letter to the Editor. Some of these may be included in upcoming publications. Also, if you have an area of expertise or interest and would like to put in an article for submission, I would love to hear from you.

Michelle E. Mason, PhD, is an adjunct faculty member at California School of Professional Psychology, Alliant International University.

OUTGOING EDITOR'S COLUMN

by Mary Cronin, MFT



Being Editor of the AFTNC Newsletter has been an enjoyable experience for me. I attended AFTNC events with the Newsletter in mind. Finding members to cover the events helped me get to know the readers and want to know them better.

I particularly appreciate that the organization is made up of people who are interested in making a difference. While focusing on updating members' clinical skills, AFTNC simultaneously addresses the context in which therapy is taking place. This approach draws members with a larger view of the profession

and its responsibilities to the family and the community. The inclusion of students in

AFTNC programs and the search for ways to address multicultural issues have broadened the membership and expanded the organization's interests and goals.

I am grateful to President Roger Lake, Contributing Editor (now Incoming President) Terry Patterson, and the Members of the Council for their encouragement, and support of the Newsletter.

Michelle Mason, Ph.D., is the Newsletter's enthusiastic, capable new Editor. Contact Michelle at mmasonpsy@sbcglobal.net to offer your suggestions and articles for future editions.

Mary T. Cronin, MFT, is in private practice in the North Beach area of San Francisco.



AFTNC Event

Sunday, February 11, 2007, 6:30 p.m. to 9:00 p.m.

Dr. Larry Diller talks about "The Last Normal Child"

at UC San Francisco's Presentation Theater

University of San Francisco, School of Education, 2350 Turk Blvd., San Francisco

In this presentation, Dr. Larry Diller offers an important new wrinkle to understanding our penchant for pathologizing and medicating different behavior and performance in children in our country. In our zeal and worry over maintaining our children's self image and self esteem, we've ironically become intolerant over minor differences in their behavior and performance (especially at school). We take them to doctors for diagnosis and treatment with psychiatric drugs, often for years. Does this make sense? Is there a down side?

In this program, non-physician AFTNC members trying to practice sensibly within a DSM, drug industry influenced culture and therapeutic model, will hear from a knowledgeable MD that some of their concerns and doubts are warranted. Dr. Diller will also offer a number of specific non-drug

interventions that will decrease their need (or the parents' need) to refer a child to a psychopharmacologist.

PRESENTER:

Larry Diller, M.D. has been in private practice in behavioral/developmental pediatrics and family therapy since 1980 in Walnut Creek. He is also an Assistant Clinical Professor at the University of California, San Francisco. He is the author of numerous articles and three books on child behavior and psychiatric drug treatment, including: *Running on Ritalin: A Physician Reflects on Children, Society, and Performance in a Pill* (Bantam, 1998); and *Should I Medicate My Child? Sane Solutions for Troubled Kids With and Without Psychiatric Drugs* (Basic Books, 2002).

His newest book, *The Last Normal Child: Essays on the Intersection of Kids, Culture, and Psychiatric Drugs* (Praeger) was released in September 2006 and is available online at www.TheLastNormalChild.com.

SCHEDULE:

The theater will be open at 6:30 PM. There will be light refreshments before the presentation. You are encouraged to come early and socialize. The presentation will begin at 7:00PM. There will be time for questions and interaction.

LOCATION:

University of San Francisco, School of Education, 2350 Turk Boulevard, San Francisco, California 94118. The best way to find the Presentation Theater is to follow this link: http://www.soe.usfca.edu/about_us/directions.html. You can easily download a campus map, which will help you to locate the School of Education and the Presentation Theater.

DIRECTIONS:

From the North: Take US-101 S toward San Francisco. Continue on Richardson Ave, Slight left at Lombard St; Turn right at Divisadero St; Turn right at Turk St. Look on your right for the School of Education just past Masonic Ave.

From the East: Take the Bay Bridge into the City. Take the exit onto Central Fwy/US-101 N toward Mission St. Continue on Octavia Blvd; Turn left at Fell St; Turn right at Fillmore St; Turn left at Turk St. Look on your right for the School of Education just past Masonic Ave.

From the South: Proceed to the City on US-101 N toward San Francisco. Continue on Octavia Blvd; Turn left at Fell St; Turn right at Fillmore St; Turn left at Turk St. Look on your right for the School of Education just past Masonic Ave.

CONTACT PERSON:

Roger Lake, AFTNC President, EMAIL: RogerLake@aol.com. Office phone: 415-567-7786, cell phone (for day of the event): 415-305-2870.

Kickoff Meeting Mentor/Mentee Program
Sunday, February 11th 4:30pm – 6:30pm, Room #110 USF
by Larah Ezrin, Student Representative

Come and join us at the University of San Francisco (USF) Campus, School of Education, Room 110, for our Kickoff Meeting! Practitioners and all students are invited to attend this meeting to discuss the Mentor/Mentee program. Graduate students are paired with a practitioner in the field of family therapy and gain an ongoing relationship for advice, direction and help along the way. This will be a casual, enjoyable event with refreshments.

Matches will be based upon areas of interest and location. Come and be a part of this exciting new project! Free of charge, AFTNC members and non-members are encouraged to attend. Practitioners and possible Mentors: Please come to this meeting with a challenging case study you have worked with, be prepared to give a brief synopsis of the case to the group for 5 – 10 minutes, and the work you did with the client(s). This will help students get acquainted with you and your work and will be a wonderful addition to the meeting.

Event location: University of San Francisco (USF) Campus, School of Education, Room 110; 2350 Turk Street (between Masonic Ave and Annapolis Terrace), San Francisco

Questions or comments: larah43@hotmail.com, Tel: (415) 377-5629

**I’VE SEEN THE FUTURE...OR
WAS THAT THE PAST?**

by Terry Patterson, AFTNC President



As we move into 2007, I first want to acknowledge my immediate two predecessors, Roger Lake and Robert-Jay Green, for advancing family therapy and keeping it front and center in our training,

practice, and thinking. As the oldest family therapy association, we have a definite legacy that involves the field’s foremost theoreticians, practitioners, and *bon vivants*. We also have an obligation, perhaps as few other organizations do, to not only keep systemic thinking alive but to advance and to incorporate recent developments, of which there are many. This message is intended as an introduction, and while I want to pay tribute to our heritage, I

want to also highlight briefly where I believe we need to go.

First, we need to re-iterate the central position of family psychology and systems thinking in general in every domain of the mental health field. I use the terms “family psychology” and “systems thinking” to refer to the field in general, rather than to a particular discipline or theoretical approach. As I look at the paucity of training institutes, the lack of more than a few family or couple therapy courses in both MFT and doctoral programs, at how practitioners view themselves as competent couple therapists with barely any specialized training, and the “dumbing down” of particularly the MFT licensing requirements, I believe our specialty has been diluted and even downgraded. Second, though I refer to it as a “specialty” (and I believe it is within psychology, psychiatry, and social work), there is ample evidence that systemic or contextual thinking is being promoted in various guises and forms within the entire mental health field, and it is, indeed, a

pervasive foundation for practice in all modalities. Third, I believe it is time for us to de-emphasize (at the same time as we define their origins more clearly) the many theoretical orientations and identify common factors that lead to effective theory development, research, teaching, consultation, and practice. Along with this third factor, we need to de-emphasize the differences among the professions and acknowledge that we practice from a common base, and that our competence depends more on our training and experience, rather than on the letters after our names. I believe AFTNC does this particularly well, and we can model this type of collegiality and promote it more in our training and practice institutions.

More on all of this later. As I look at these issues, it seems that the field was more in synch with these ideas in the 60s and 70s in some places, and we need to look back and forward at the same time. Please contact me at pattersont@usfca.edu with any ideas you may have, and plan to attend our February 11th event at USF, our September 29th conference in Sonoma, and other events to be announced in between. Have a peaceful and fulfilling 2007, filled with warm relational developments and growth.

Terry Patterson, EdD, ABPP, is a Board-certified Family Psychologist, a Professor at the University of San Francisco, and a specialist in couples therapy in independent practice.

A REPORT FROM THE 43RD AFTNC CONFERENCE

by Cheryl Deaner, MFT

Those of us fortunate enough to be able to attend the 43rd Annual AFTNC Conference at Sonoma's Westerbeke Ranch enjoyed a long weekend of toasty-crisp fall weather and delicious southwestern food under a full harvest moon.



This congenial backdrop put us in a fine mood to soak up the words of this year's presenter, Dr. Bill Pinsof, who spoke about "Transforming Conflict and Building Love: Integrative Problem-Centered Couples Therapy."

Dr. Pinsof has an extensive background as an academic and a clinician. President of the Family Institute and Director of the Center for Applied Psychology and Family Studies at Northwestern University in Chicago, he is also the author of *Integrative Problem Centered Therapy: A Synthesis of Family, Individual and Biological Therapies*. His breadth of experience, along with his enthusiasm for communicating what he knows, created a spirited and instructive teaching atmosphere for our conference.

Dr Pinsof (Bill to us) delivered his workshop in a practical and understandable style. Comfortable sharing what he knew, he was also comfortable admitting the limits of his own personal experience, such as in working with issues of non-traditional gender identity. Additionally, he acknowledged that the pragmatic nature of this theory limits its content. For instance, a therapist would not acknowledge a male/female power imbalance if the couple did not identify this as a problem.

So what is Integrative Problem Centered Therapy? Says Dr. Pinsof, "It is a theory with an underlying systems framework applied to all of its different components." Put another way, this theory *integrates* components of distinctly different schools of therapy to create a powerful systemic approach. Were the components not so closely bound, this approach would look eclectic.

An Integrative Problem Centered Couples therapist's main task is to help a couple solve its presenting problem. What the therapist actually thinks the client's problems are is irrelevant. As Dr. Pinsof puts it, "the couple has come to therapy to solve their problem, not to hear what we think their problem is. We just have to get over ourselves!" The only exception to this

client-defined approach is when a couple is in severe crisis, such as in cases of domestic violence or active drug/alcohol addiction.

The couple's presenting problem is central to this theory because it is seen as the primary symptom of a couple's "Problem Maintenance System" (or PMS for short). A PMS is a faulty relational pattern that a couple is powerless to overcome without help. The therapist's job is to help give the couple the tools they need to dismantle their PMS. Once the PMS has been broken through, the couple can solve their problems again and therapy is over, unless the couple develops another PMS, or needs to periodically reinforce what they have learned.

When a couple starts treatment, the therapist will always "assume a premise of least pathology in which couples are held to be psychologically healthy unless they prove themselves to be otherwise," says Dr. Pinsof. This allows the theory's most cost effective and time saving components to be introduced first. If the problem still remains after using these, a continuum of other theoretical components will be cycled through.

Although a therapist can alter the order in which these components are introduced, they can seldom go wrong with at least a cursory sweep through the component's ordered system. This rather methodical feature of the theory is part of what can make Integrative Problem-Centered Couples Therapy a good fit for interns – provided they have sufficient training in the theoretical components used by this model to be able to effectively employ them.

Here is a superficial description of the components of Integrative Problem Centered Couples Therapy. The first component is behavioral because, in an otherwise healthy couple, behavioral change may be enough to end a couple's problem. If not, a "bio/behavioral" (a medical and or a medication intervention) is explored. If the problem remains, an experiential component, in which

the therapist encourages the couple to understand the underlying meanings of their problem, is examined. If insufficient, the therapist introduces a family of origin component. For example, how might one's family, past and present, be contributing to the couple's problem? The next ordered component is an object relations lens. The therapist explores a couple's "internal objects" and helps them to dislodge the patterns that may be unconsciously maintaining the couple's problem. Finally, if all else fails, a self-psychology approach is introduced. The therapist may determine that one or both members of the couple are not capable of working in a triangular way with a therapist, because, as Dr. Pinsof says, "Not all adults have developed a capacity for self-object relationships." One or both of the couple may be sent to individual treatment to shore up their sense of self via a therapeutic alliance before returning to couples work.

Integrative Problem-Centered Couples Therapy, as practiced at the Center for Applied Psychology and Family Studies at Northwestern, creates a rich source of research statistics. All clients fill out an information-gathering tool known as the STIC (the Systemic Therapy Inventory of Change), before their first session, and again at appropriate intervals. The STIC helps the Center keep track of the 43,000 (!) sessions of therapy delivered each year. This tool (along with homework between sessions) helps clinicians to know what is really going on with their clients.

Although Integrative Problem-Centered Couples Therapy can be viewed in a fairly straightforward manner, and its systems orientation can be instantly appealing to family therapists, this is actually an elegant and intricate theory and there is much more to it than I can outline here. If this brief overview has piqued your interest, please order Dr. Pinsof's book, *Integrative Problem Centered Therapy: A Synthesis of Family, Individual and Biological Therapies* (Basic Books, 1995).

In closing, I would like to add a personal note. This was my first AFTNC conference and I am pleased to have discovered that it is comprised of such a diverse group of engaged – and engaging – family therapists.

Cheryl Deaner, MFT, is in private practice in San Francisco.

Student Event CAREER OPTIONS IN COUPLE AND FAMILY THERAPY

*by Sara Mizban, AFTNC Student Representative
& Event Co-Organizer*

Instead of its usual February date, the AFTNC Annual Student Event started off the school year and took place in mid-September. Thanks to some wonderful people at Alameda Family Services, a non-profit agency that provides services to youth, families and children, the event took place at their site in Alameda. The event started off with a nice welcome and introduction from all the board members, which was quite a treat. Our wonderful panel spoke intimately about their personal and professional lives, including topics on how they got to where they are today, some of their challenges and solutions, and on issues that pertain to students who wonder about the realities of post-graduate life. Their diverse backgrounds and various interests were informative to students from all courses of study.

Karlotta Bartholomew, a PhD who has her own private practice and who works at Kaiser two days a week with families and teens, started off the panel. Coming from a social work background, Dr. Bartholomew described her journey in becoming a psychologist and some of her values and philosophies, including her “eco-systemic” perspective and her emphasis on understanding the importance on context.

Jane Ariel, PhD, talked about the building of her private practice and all the practicalities of running your own practice. She described the consultation group she’s involved in and her

work with reflecting teams, unique ways she expands her therapeutic framework and copes with the isolating nature of private practice.

Becky Pizer, PsyD, the training director for Alameda Family Services, spoke about therapist burn out, something familiar to everyone in this field, and the importance of self-care. In describing her experiences with non-profit work, she encouraged students to take advantage of their training in figuring out what types of work and environment are a good fit for them.

David Shaw, MS, MFT, currently works with children and adolescent programs in Contra Costa County Mental Health in Richmond. He spoke about his 28 years of experience working for the county, the challenges one faces working in large, multi-layered organizations, and how to utilize supervision to find one’s strengths when working with challenging populations.

Linda Klann, MA, MFT, talked about how to “stand out” in our psychologist-saturated city through finding your niche and marketing. I was amazed at all the different programs Linda is a part of aside from her private practice, including Kids Turn, Children’s Psychotherapy Project, a Victims of Crime program, and more!

This is just a glimpse of all the great information that was presented that day. The wisdom and desire to give to those of us just beginning our journey in this profession (including me!) truly radiated throughout the room. Additionally, the beautiful weather, cozy setting, enthusiasm of the students, and yummy food made the day a success. Thanks again to all the panelists and those who came out for the event!

For our members who have not met us, Lara Ezrin and I are the AFTNC Student Representatives. We each share responsibility for organizing events of special interest to AFTNC’s student members and other new members in the field. At this time, Lara has put

together an event for the AFTNC Mentor/Mentee program, which will happen on February 11. Check out the announcement in this edition of the Newsletter for details. If you have helpful feedback or great ideas for upcoming events, please contact us!

DON'T DRUG THEM:

Parents' obsession with their children's self-esteem plus profit driven diagnoses create a dangerous prescription

by Lawrence Diller, originally published in Insight, San Francisco Chronicle, Sunday, November 19, 2006

In our zeal to help our children feel better about themselves, are we really doing them any favors, or could we actually be hurting them? It's counterintuitive, but our worries over our children's self-image and self-esteem may be unwarranted and unintentionally lead to unnecessary medical intervention and possible harm.

I've come to this opinion after evaluating and treating over 2,500 children for attention deficit/hyperactivity disorder, the condition that has become the explanation for virtually all children's underperformance and misbehavior at school.

November is a busy month for me because it's time for the first parent-teacher conferences prior to the year's first report card for most schools. And this time of year parents are all asking the same question, "Does my kid have ADHD?"

As someone who has prescribed drugs like Ritalin, Adderall and Concerta to children for more than a quarter century, I've become very uneasy about how much medication we use in this country. In 1998, I wrote a book called "Running on Ritalin," which examined the factors that might explain the phenomenal growth and use of this drug in the United States.

However, I came to realize my analysis of the ADHD/Ritalin epidemic was incomplete. Nor did I sufficiently explain why parents of less and less disabled children, parents of children as young as 2, or the kids themselves (especially teenagers) were seeking the ADHD diagnosis and medication. Neither was I entirely clear on why parents were also interested in medications like Prozac, whose use in children has also grown exponentially in the last 10 years.

These parents weren't after perfect "trophy" children. They loved their kids but were worried about them. It occurred to me that it was their worry over their children's feelings, especially their self-image and self-esteem that was driving this epidemic of psychiatric drug use. In our concern about our children's feelings, we've ironically become less and less tolerant of minor differences or variations in their behavior and school performance.

Several years ago, I treated an 8-year-old patient who had an IQ of 130 but was getting only B's and C's at his private school because he wouldn't turn in his homework despite his teachers' and parents' best efforts. He was more focused on reading adult level texts about the Sahara desert, his current interest. But he was feeling worse and worse about his less-than-stellar grades, so I ultimately prescribed Ritalin for him. After that experience and many similar ones, I began to wonder if someday I'd be seeing "the last normal child" in my office.

This concern about our children's feelings reflects a profound change in our society's values over the past four decades. Our beliefs have shifted away from religion and meaningful politics to an obsession about caring and believing in ourselves.

In the process, how we feel has become much more important to us, and we expect (and possibly demand) that we feel good. And that's especially true for our children.

Yet despite much popular belief, there is little evidence that in the long run children's views of themselves make any difference.

Most of the original work on self-esteem was based on retrospective interviews (notorious for creating distortions). It didn't matter whether the subjects were now CEOs, artists or criminals. All of them seem to have had lousy childhoods. Both the successes and the failures in life told researchers that as kids they suffered low levels of self-esteem. And more reliable types of studies have failed to prove that high or low self-esteem in childhood is predictive of good or bad outcomes later in life.

Whatever its influence right now, a child's self-concept appears to have little long-term influence.

Still, we want our children to feel good, right? But what if that means taking them to the doctor, getting a diagnosis that may have lifelong implications and taking a medication potentially for years? Does that make sense? Is it the best thing for our children?

ADHD has become the ubiquitous way we view problems of children's behavior and performance. While the Centers for Disease Control report 2.5 million children take a medication for ADHD, most research epidemiologists say the number is closer to 4 million. A more precise gauge comes from a medication insurance clearinghouse report that shows nearly 1 in 10 11-year-old white boys is currently treated with a stimulant such as Ritalin.

The amount of legal stimulants used as medication and produced in our country has grown 2,000 percent in the last 15 years. Data from the U.N. Narcotics Control Commission has been consistent over the years: The United States consumes 80 percent of the world's legal stimulant drugs (this does not include our use of illegal stimulants like cocaine or methamphetamine).

More parents, teachers and doctors are ready to accept a biological explanation (an ADHD diagnosis) and a medical treatment for children's underperformance at school, where children are being asked to learn more at an earlier age. With more two-parent working families, parents have less time to spend with their kids, either for monitoring homework or having fun.

Our discipline practices have changed. We put forth much more effort in talking to our kids about bad behavior before we take action (a style poorly suited for the hyperactive mind).

Money also plays an important role. Insurance companies reward doctors more for brief "med checks" than longer talking sessions. The doctors make more money by prescribing and the drug companies make money, too.

Indeed, the single biggest influence on the way we think about our kids' problems may be the power the drug companies have on the doctors' behavior, medical research and teaching (mostly funded these days by drug companies), and advertising directed to the consumer (parents and teachers).

Yet the bedrock supporting this epidemic is our love, fear and worry over our children's present and future feelings. Must we make a pathology of our children's struggles and treat them with psychiatric drugs for "their own good?"

I suggest there is another way. Perhaps, the primary reform we should undertake as a society is to breathe a "collective sigh" about our kids. Things will likely turn out well for most of the offspring of the middle-class families who bring their kids to the doctor's office for evaluation.

Don't forget that some of our greatest strengths are the result of compensating for our weaknesses.

Also, there are a number of simple actions we could take to help our kids that don't involve using a psychiatric medicine at all.

First, we should make a concerted effort to involve fathers more immediately and directly in the evaluation of their children's behavior or school performance. In my years of practice, I can recall only about a dozen fathers who lived in the area who refused to participate in an evaluation, especially if I called the dad directly.

Father's involvement is critical. He often has a different perspective than the mom (he generally sees less of a problem because he's around less and also stereotypically is more effective with discipline). His participation with any behavior plan (or medication treatment for that matter) makes its success far more likely than without him.

Second, all kids should have a minimal educational evaluation at school or by the doctor before they are started on a medication. So many of the children I see have learning or processing problems that have been ignored. It's no wonder they are looking out the window when the teacher is talking if they have an auditory processing disorder (or another learning problem). Yet over and over again, I get kids referred who have not even been screened by their school.

Finally, I make a direct plea to my colleagues in child psychiatry and behavioral developmental pediatrics. You, who have achieved the pinnacle of power and expertise within the community to evaluate and treat children for these problems, are spending way too much time in your offices "diagnosing" disorders and dispensing pills. Instead you should be going out to the schools to attend individualized educational plan meetings to coordinate an effective behavioral-educational plan between the school and parents. Over and over, parents tell me the single most valuable effort I made in helping their child was the 45 minutes I spent with them at such a school meeting.

I know there's a core group of kids that -- no matter what you do for them -- will need these medications, but I think this group is about one-tenth of the number we treat now.

We too often forget that medication is not a moral equivalent to helping children cope with what has become an increasingly perilous journey through childhood.

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AFTNC 2007 CONFERENCE

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