Developmental psychology is concerned with the description and establishment of developmental levels as well as the establishment of the genetic relationship between levels and their formal aspect of development.

In developmental psychology there is an upward developmental direction and movement in the direction of increasing differentiation from level to level. Along with the increasing differentiation there is an increasing subordination of earlier content and a hierarchization of events and functions.

In the area of feelings for example, this differentiation occurs from the sensori-motor to the body signal system to linguistic concepts as we progress in development. The sensori-motor and body signal system becomes subordinated to the higher conceptual levels and is hierarchically integrated into the whole emotional response system with increasing development.

The more differentiated and organized the mental structure of an organism the more flexible or plastic the behavior becomes. The less differentiated and hierarchically patterned the more rigid yet less stable the behavior becomes. Stability of behavior requires flexibility of response in order to preserve the functional equilibrium of the organism.

A Letter to Parents About ADD & ADHD.

In the past thirty years there has been a marked increase in the diagnosis of children and adults with ADD and ADHD. There are many factors which contribute to this increase in diagnosis. While I do believe that both of these diagnosis are real and do exist, the over utilization of them has its origins in politics, misunderstanding, inappropriate placement of the diagnosis on the medical profession and insufficient history taking by those doing the diagnosis. It is a beautiful (or not so beautiful) example of our use of cross sectional medicine instead of historical medicine.

Cross sectional medicine is simply the listening of symptoms and treatment of symptoms. It is an attempt at "quick and dirty" treatment and seeks medications to quell the symptom. It is epitomized by our society's trend toward the instants –instant foods, instant happiness, instant pleasures and instant gratification. Managed care likes cross-sectional medicine.

Historical medicine is simply the search for the origins of an illness and the treatment of the source of the illness. It is epitomized in psychology by the theories of developmental psychology, Freudian and Jungian Psychology. It is realized by careful history and a mindset of cause and effect. Managed care does not like historical medicine.

The fact that there is no medical test for ADD & ADHD – only symptom checklists as reported by teachers, parents and often the subject himself, further complicates accurate diagnosis and can even question the existence of the entity as a true medical condition. Now remember – I do believe that there is such a diagnosis.

The politics of this over-diagnosis is very interesting. Back in the early 1970s children were seldom diagnosed with ADD & ADHD. During that era children's learning disabilities were a significant problem in the schools. Texas and Colorado led the nation in the diagnosis and educational treatment of learning disabilities as it should have been. The estimate of significant problems was about seven percent of the student population with as much as twelve percent needing educational remediation – especially in the first three grades where the disabilities had the best chance of remediation. Learning disabilities include many areas but the following are a few of these: Dyslexia, sensori-motor integration problems, auditory and visual receptive and expressive disorders, and the more complex central integration and mediation of information disorder.

During this era the public schools had school psychologists, educational diagnosticians, speech and language therapists, occupational therapists and teachers specifically trained in the remediation of learning disabilities.Systems in the colleges and universities were being established to train teachers in the diagnosis and remediation of these disorders. The public schools also had differential diagnosis and educational programs for emotionally disturbed children.

In the mid 1970s all of that was changed by a federal public law (94142). This law mandated that all handicapping conditions be admitted to the public schools – the blind, the deaf, and all conditions of the physically disabled. The federal government in its wisdom demanded special programs in the public schools for each of these conditions. This was to include special PE programs, teacher supervision and up to one on one teacher student education for the disabilities that needed it.

The law required that any diagnosis of disability done by the school have educational programs suited to the diagnosis. It also expected the school to have educational programs for any medically diagnosed problem by physicians. Big problem – the federal government did not fund the law in any sufficient manner to enable the schools to carry out its order. This meant that local school districts had to finance these programs or they would be in violation of the law. For me to be brief, the following were the results:

1. Most all educational diagnosis ceased in the schools.
2. Money allocated to existing programs (already in shortage),especially learning disabilities and emotional disability programs was re-allocated to implement the public law.
3. Diagnosis of children with symptoms was sent out of the schools to physicians, pediatricians and family practitioners who had no training or expertise in differential diagnosis between these educational and medical problems.
4. Children with learning disabilities, emotional problems and true ADD & ADHD have very similar symptoms but very different causes.
5. Physicians were asked to do the checklists of symptoms and treat them with medication.
6. The majority of good special-ed programs in the schools were shut down because of lack of funds. They still are grossly under funded and without necessary educational programs to even handle the 7-12% of learning disabilities and 5% (estimate) of significant emotionally disturbed children.
7. Most of these children mis-diagnosed – are placed on medication to help control the symptoms.

Now under new public laws of a year ago the diagnosis of autism and Asperger's syndrome is the “in” diagnosis necessary to obtain special education benefits – whether or not this diagnosis is appropriate. The result is again a marked increase of a real existing problem with significant inappropriate and over diagnosis in order to “fit” a program.

To add to this serious political problem is a marked change in child rearing practices over the last 30-40 years. While many of these practices are for the good in the long run they also produce significant side effects which contribute to the ADD & ADHD problem. Again, to be brief:

- More children are out of control with themselves.

- More children have fewer limits and boundaries set by parents.

- Parent consistency has decreased with both parents having less time.

- Children are allowed greater freedom with less discrimination between home and public behavior.

- "Free" children show less respect to other adults and children.

Finally, in some of the work and writing that I have recently done, the recognition of intelligence and activity level as givens- that is something that we are born with and that does not change significantly during our lifetime – have to become variables in sorting out the issues of ADD and especially HD. Specifically, in high activity children, at what point does it become hyperactive, or, is it merely a highly active child who will always be that way? The differential diagnosis of this issue is based in part on the other "given" of intelligence and on the child's ability to channel his high activity into different constructive educational areas often not provided by the educational system for these "demanding" children.

To medicate a high-activity child whose symptoms may resemble hyperactive children without correct differential diagnosis to satisfy an unprepared educational system would border on criminal and could even lead to class action suits.

Needless to say the problem of ADD & ADHD is a significant one, one without simple solutions but one which requires serious historical and educational differential diagnosis before any medication is recommended for the child or adult delinquency and other behavior problems. It is time to be accurate in diagnosis and to find the appropriate treatment for the given condition.

-Laurence, February 2007

Who's in Control

With the changes in parenting that have occurred during the past thirty-five years (Since the early 1970's) there has been an increase in the number of children who seem to be out of control. This lack of control is seen in the classroom, in public places such as stores churches and restaurants, and when the children are with other adults. This has resulted in many parents turning to psychologists for behavior control and to doctors for medications to control the behavior, best epitomized in the excessive diagnosis of medication and treatment of ADD, ADHD, and now Bipolar Disorders.

Parents who no longer believe in physical punishment and often don't set clear boundaries for their children are at a loss for alternative means to "control" their child's behavior. In addition, in households with both parents working it is difficult for the working parents to come home and be disciplinarians to their children in a consistent manner. Grandparents, childcare schools and sitters are often turned to for implementing attempts to "control" the child's behavior. The lack of consistency between these parenting systems further complicates the correction of the misbehavior.

Certainly, all children do not fall under the rubric of "out of control" children. Fortunately, many children have personalities that can readily adapt to the different limits that are set in the home, school and aftercare. They can also easily distinguish between adults who "expect" behavior within certain limits from those who don't. While these children may be constitutionally different, they too can benefit from the following proposed approach.

This approach requires a fundamental shift in belief if it is to be successful. While we all acknowledge that self-control is each one of our personal responsibilities, we do not operate out of that framework in child rearing. Indeed, we function as if each one of us who comes in contact with the child is responsible for controlling him or her. The greater the parental role the greater the responsibility we have in controlling this behavior. Parental role is defined as whoever is in charge with the child - whether it be parent, teacher and child care worker.

There is also a new breed of parent who feels that letting the child act naturally - requires no external or internal control. For them the child's inappropriate behavior does not become a problem until it has reached the level of interference; interference with other children learning, with social expectations of others, with other adults leading their lives or carrying out their duties. It is often at that point that the psychologist becomes involved.

After having seen a proliferation of these families and children during the past 10-15 years I have used this very simplified approach to child behavior which begins with an equally simple premise - that we all have to learn to control ourselves at some point in our life. This notion of self-control is taught so the child learns very early to internalize the idea instead of having to fight with authoritarian figures over issues of control or no control. For most parents this requires a fundamental paradigm shift away from their responsibility to control the child to the child's need to control him/her self. This shift also requires a major mind set change and as simple as it sounds, is extremely difficult to do.

When done successfully, it removes the parent or teacher from the position of behavior control to the position of identifying for the child when he or she is out of control (as appropriately defined by the parent or teacher). The supervising figure then calls the child on it by saying "MAX YOU ARE OUT OF CONTROL WITH YOURSELF AND YOU HAVE TO GET BACK IN CONTROL OF YOURSELF". The child then is told to take a time out. The time out is what practically works for the situation. It can be his room; a seat on a chair, going to the car with the caretaker or other designated place that brings about success. "GO TO YOUR ROOM UNTIL YOU ARE BACK IN CONTROL OF YOURSELF. THEN YOU CAN COME OUT."

The length of time for the time out becomes dependent upon the child's recognition that he is back in control of himself. If the child care person does not think that he has attained that self control, the out of control behavior is described to the child and he is told that he cannot remove himself until he has gotten control of that behavior. The process of success in this method is slow. It is the consistent and repetitive identifications of out of control behavior that eventually helps the child to learn what is socially determined as "out of control" behavior. The turning point comes when the child says to himself or others "I'm out of control with myself" and self limits. If the parent has any similar out of control behaviors (i.e., yelling, swearing, getting loudly angry etc) do not be surprised if the child says "mom (or dad) you are out of control with yourself". It is extremely important for the parent to own this behavior and model for the child: "You are right - I have to take a few minutes to get back in control". This modeling effect helps all involved to maintain better self-control.

As usual there are not miracles in this or any other approach. For this to work all figures involved in the care of the child have to agree to the approach and have to be capable of moving from the "I'll control him" position to the belief that his learning to get in control of himself is an appropriate goal. This system is simply giving the child a way to do this. In so doing this the child defines family, school and societies expectations of appropriate behavior.

The caretaker's role becomes:

1. To identify the out of control behavior
2. To be consistent
3. To be persistent with the child until he grasps the notion of self-control.

The child quickly learns
1. When he is out of control
2. What he has to do to regain control
3. That he has accomplished mastery of himself.

This is a major growth experience and confidence builder. Children out of control with themselves do not feel good about it and grow into adolescence with much greater problems than those who have self-mastery.

Once you are ready to begin this approach it is important to define the change to the child ahead of time just like it is whenever there is going to be any new rules. For example, “WE ALL HAVE TO LEARN TO CONTROL OURSELVES - MOM AND DAD AS WELL. WE ARE GOING TO HELP YOU LEARN HOW TO DO THIS BECAUSE ITS YOUR JOB. YOUR OTHER CAREGIVERS ARE GOING TO HELP YOU AS WELL.”

If the child is old enough to understand language (for 2-3 on) then an example is appropriate.
"When you yell and scream, hit your brother, start to lose it in the store, we will tell you that you are out of control with your self and you have to regain your control. You may help us by choosing one of these ways to get back in control; sit in your room, sit on the stair, sit in a chair or go to the car with me until you feel like you are back in control. Which of these choices do you want to do?"

This empowers the child to choose whatever he thinks would work for him. If, after several trials it doesn’t work, then you define it and say “this didn’t work, you have to choose some time out that will work." We know that you will feel better about yourself and I will feel better also when you have better control of your self.

In the weeks that follow it is very important for the caregiver to praise the child spontaneously. “You know I’ve noticed how much better control you are in and how much happier you are because of it”. Special notice with examples will be very reinforcing to the child and further help him or her with feelings of positive self-worth.

If you and your caregivers all subscribe to this approach (change your belief from I have to control him to he has to control himself), do it consistently, then I guarantee behavior change usually within a couple of months. Do not think that 1. This is easy, 2. That you can slack off, 3. That you can stop after a couple of months. This is a life long

approach that builds positive self-esteem and that we all have to continue to improve upon. It is fundamental in building a strong family and a strong society.

Your recognition and definition of "out of control" behaviors have to be fair, equal to all your children and agreed upon by all the caregivers. At the same time there can be individual differences between caregivers as to what behaviors the child has to get control over. You have to remain flexible in application but not in principle. As the child improves there has to be random comments to the child about how proud you are of him and how good it makes him feel and you feel when he is in control of himself. Also it is important to comment about how good it makes you feel about yourself when you retain greater self-control.

As an aside it is important to recognize that the only two causes of primary anger are perceived unfairness and control issues. Control issues mean that it is predictable that if you try to control someone (child, especially adolescent, and or your spouse) and they don't want to be controlled - they will get angry at you for trying to control them and you will be angry at them for them not being easily controlled. With this psychological switch to self-control - the only person that the child can be angry at is himself for being out of control. If that happens then dealing with that will be dealt with in a different letter to parents.

April 2007
San Antonio

Thoughts on Homosexuality from a Developmental Perspective

The following is a developmental hypothesis based on some limited empirical evidence which hopefully will give rise to heuristic research.

The initial hypothesis is that homosexuality is a complex issue which has three distinct developmental phases. It is both genetically given and developmentally learned depending upon the age of introduction. Generally, homosexuality can be divided into three groups, which I will call biologically given (Group I), Imprinted (Group II) and Experimental (Group III).

Each of these groups are clearly age-related in terms of identification, exposure and experience. The first of these groups is the biologically given, probably hormonal dysfunction while in utero. The cause of this has been studied unsuccessfully. There has been research on the double x y chromosome and a number of other genetic possibilities. As we become more sophisticated there are a few hints at some other genetic and hormonal links but nothing conclusive.

Behaviorally this first group is self-identifying, typically by effeminate boys and tomboy girls. By that I mean that each male or female in this category recognizes at a very early age (3-5) that they are different than their sexual peers. The boys “know” and the girls “know” that they don’t fit with their sexual identity companions. They feel that they are in the wrong skins i.e., the boys feel that they should have been girls and the girls believe that they should have been boys. Parents may have noticed this difference and encouraged it either consciously or unconsciously, but in either case the parent did not cause this difference.

These children have interests that are similar to the opposite sex, their childhood games are of the opposite sex, and their identity is of the opposite sex. I have absolutely no doubt that this group of homosexual’s will eventually be found to be genetically or hormonally different than their peers from conception or first or second trimester of development. This group is predetermined to be interested in the same sex as partners - they have no more "choice" than their peers have a "choice" to be heterosexual. They cannot change, anymore than a heterosexual can purposefully "change" to be homosexual. Group I individuals may spend years in conflict over societies desire for them to be "straight" They may try program after program to convert them to their "right" sexuality. All of this will be unsuccessful.

The second group (the imprinting group) is developmentally determined during the latency period -when sexuality should be quiescent - between the ages of 6 or 7 and early onset of puberty - 10-12. This group of individuals, male and female - have been approached by a member of the same sex - either another sexually precocious person or one in pubescence, or an adult. They have been introduced to homosexuality frequently or repeatedly during this presumed quiescent period. This "sexual" imprinting by the same sex partner has a dramatic effect both physically and emotionally on the "normal" child. Because of the power of sexual pleasure, it teaches sexuality long before the child is ready. It also

teaches desirability by the same sex initiator. Because this is normally a quiet period sexually, the same experience with the opposite sex seldom occurs leaving the unsuspecting child with the belief that homosexual contact is "normal" and reinforced by his or her being accepted by the same sex and not by a heterosexual sexually. Indeed, at these early ages heterosexual acceptance is developmentally inappropriate. This often-reinforced experience may make him or her seek same sex partners at the ages when sexuality is generally forbidden. This "imprinting" effect is a function of a number of partners and repeated sexual contact with the same sex at the ages of 6-7 to 10-12.

In this group as they reach adolescence, they struggle with the question of their sexual identity but more often than not they "know" that they are going to select the same sex partner. There may be sexual exploration with opposite sex partners during adolescence but their inexperience with them and their discomfort with the same sex partner over-rules. Occasionally a very successful heterosexual experience may sway them but only to confuse them further. They have been successfully imprinted.

Possibility of change in sexual orientation becomes a function of frequency of imprinting with the same sex partner. That is, the greater the frequency in these early ages the less chance for change. The less frequent the imprint, the greater the chance for change. As you can see "change" has many variables and is not an easy expression of will - I want to or I don't want to.

The third developmental group is the typical adolescent, approximately age 13-18. In this age group there may be experimentation with the same or opposite sex. This is usually considered a normal variant for this age. However, another variable enters here. The individuals normal sex drive. Sex drive itself is a given. Those with high drive will normally look for a greater variety of experiences while those with a lower drive will limit their exploration. At these ages initial contact with the same sex or opposite sex becomes important in determining sexual preference. Also sexual contact of an opposite nature from initial contact adds another complex variable. If there is repeated contact with the same sex or with
the opposite sex then sexual preference is usually set. Acceptance by the partner becomes another complex variable, which helps determine preference.

In this third group there are currently too many variables to accurately predict the formation of preference. Suffice it to say that bi-sexuality, homosexuality and heterosexuality derive from these adolescent experiences. If the issue of change in preference ever exists - it does so where sexuality was determined during adolescence.

The heuristic value of this developmental theory of sexual preference demands research. Once there is adequate research some conclusions about accepting all human beings as equals regardless of sexual preference can be put to rest. The reduction of prejudice for unchangeable givens, whether it be male, female, white, black, gay, heterosexual can ideally lead to a greater bonding of the human race.

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Questionnaire

Developmental Aspects of Sexual Identity

Which of the above groups do you feel that applies to you?

Group I Yes No

Group II Yes No

Group III Yes No

Other - Please describe in your words

Group III Was your first sexual contact with the same sex? Yes No

How old were you?

If yes, how many same sex contacts were there?

Was there heterosexual contact at some point? Yes No

If yes, how many heterosexual contacts were there?

Was your first sexual contact with the opposite sex? Yes No

How old were you?

If your first sexual contact was with the opposite sex, how many heterosexual contacts were there?

Was there same sex contact at some point?

How many same sex contacts were there before choosing a sexual preference?

Do you now have a clear sexual preference? Yes No

Which of the following best describes your current sexual preference?

I am a clearly defined homosexual

I am a clearly defined heterosexual

I am bi-sexual

I consider my sex drive to be:

Low: once a month or less

Medium: once a week or less

High: more than once a week

Extremely high: once a day or more

I generally have a sexual experience with myself or others:

Once a month or less

Once a week or less

More than once a week

Once a day or more

Please e-mail questionnaire results to: lcsjrphd@sopris.net