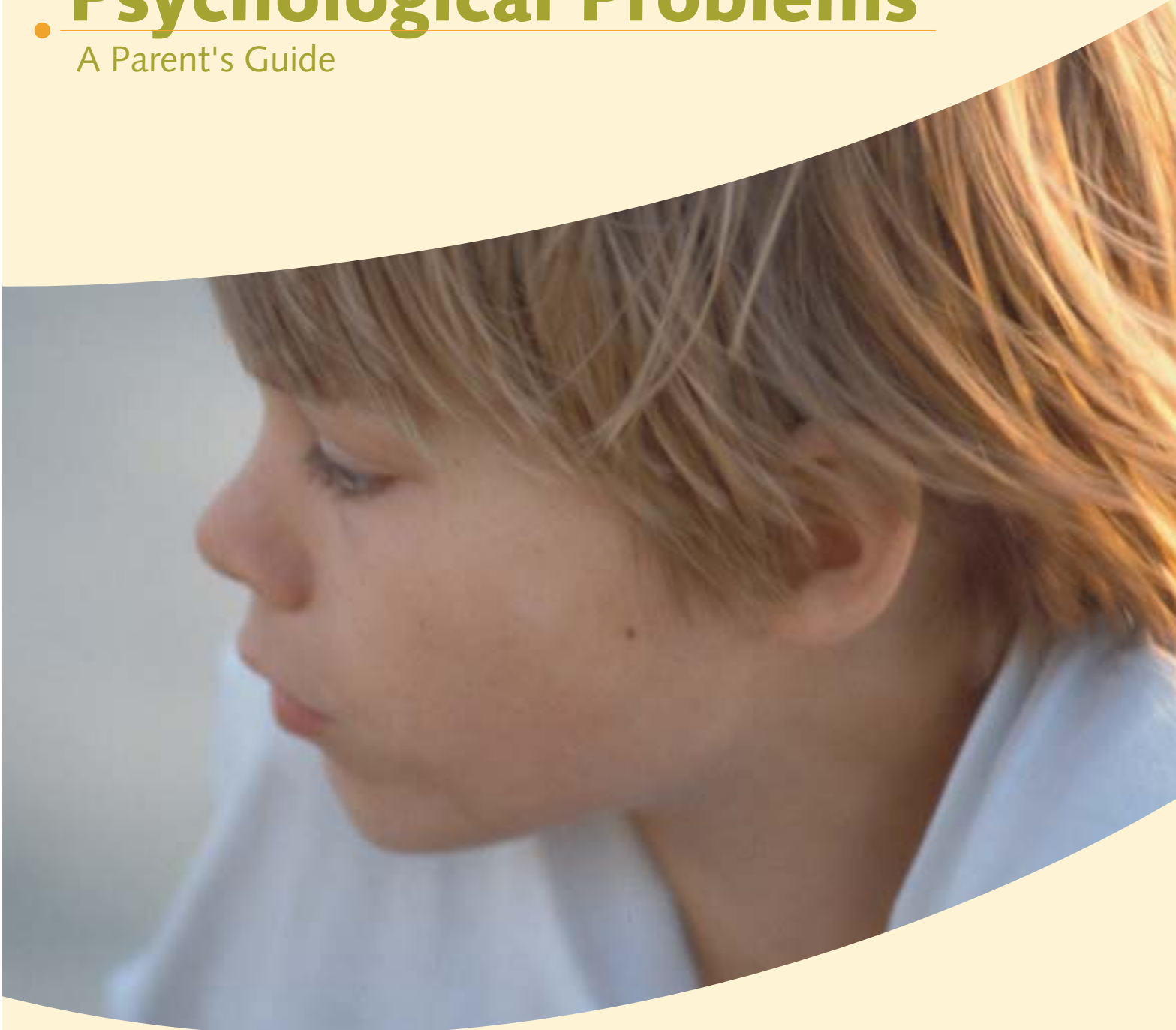



# Psychological Problems

A Parent's Guide



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## **Psychological Problems: A Parent's Guide**

Children who struggle with learning may become sad, frustrated, or ashamed in response to their difficulties. Often, they experience psychological problems such as anxiety, depression, or excessive anger. This guide includes articles and interviews, featuring researchers and clinicians who are experts on psychological problems affecting kids with learning challenges. They describe symptoms parents can watch for and ways to support a child's psychological and emotional well-being. You'll also find a list of suggested resources on this topic.

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## A Parent's Guide to Psychological Problems

### Learning Disabilities and Psychological Problems — An Overview

Children with learning disabilities (LD) often have problems that go far beyond those experienced in reading, writing, math, memory, or organization. For many, strong feelings of frustration, anger, sadness, or shame can lead to psychological difficulties such as anxiety, depression, or low self-esteem, as well as behavioral problems such as substance abuse or juvenile delinquency. “Unfortunately,” says Dr. Marshall Raskind, an expert in the field of learning disabilities, “these problems can be far more devastating than the academic challenges themselves. Although the severity and duration of a child’s psychological difficulties may vary as she grows up, such issues can find their way into and through adulthood.”

Several leading experts in the field of LD have researched the psychological difficulties often experienced by children with LD and have offered suggestions to parents on ways to help protect their children from developing these problems. In this overview article, we will describe in general terms what kinds of psychological problems may affect kids with LD and their possible causes. We will also provide some warning signs parents should look for and direct you to some approaches that can support your child’s psychological well-being.

Forthcoming articles in this series, which are being developed over the next few months, will explore specific psychological issues that many children with LD face, such as anxiety, depression, and loneliness.

#### Some Explanations for Psychological Difficulties in Kids with LD

To be most effective in supporting your child, it can help to understand some presumed underlying reasons for the psychological and emotional challenges she may face. Although there are a number of theories on why kids with LD may develop these problems, there are two often cited explanations. First, **it is not difficult to see why children with LD are at greater risk for developing psychological difficulties if one considers the repeated failure they experience as they fight their way through the educational system**, which may misunderstand or ignore their needs.

**Despite the child’s efforts and adult promptings to “try harder,” children with LD may receive little positive feedback.** Their academic struggles and failures are often met with disapproval by teachers, peers, and parents. Such disapproval can take the form of negative labeling of a child as “slow,” “lazy,” or “dumb.” Rather than developing a sense of pride in their accomplishments, children with LD may end up in a quagmire of frustration and shame.

Such feelings only serve to erode the development of a positive self-concept. In fact, as a result of constant struggle and failure, a negative self-image may develop even when others offer support and encouragement. Low self-esteem and a lack of confidence only serve to further interfere with learning and academic success and reinforce a cycle of failure and negativity. **Research conducted by Dr. Kenneth Kavale of the University of Iowa and Dr. Steven R. Forness of the University of California at Los Angeles indicates that as many as 70% of children with LD suffer from poor self-esteem.**

“To be most effective in supporting your child, it can help to understand some presumed underlying reasons for the psychological and emotional challenges she may face.”

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“Over time, children with LD may just stop trying,” Dr. Raskind says, “entering a state of ‘learned helplessness’ where they see little connection between their efforts and ultimate outcomes. ‘Why bother?’ they may ask, ‘No matter how hard I try, I always end up failing.’”

The second frequently offered reason as to why kids with LD may develop psychological problems is the social difficulties they often experience. Research by Drs. Kavale and Forness indicates that as many as 75% of kids with LD have social difficulties such as making and keeping friends. “In fact, social and psychological problems are so interconnected,” Dr. Raskind comments, “that it may be quite impossible at times to determine which one may have caused the other. Certainly, psychological problems can have a negative effect on social interaction. Research has shown that children with learning disabilities are less accepted, and often rejected by their peers. Teachers and other adults also may tend to have negative views of children with learning disabilities.” Such social rejection can result in loss of self-esteem and negative views of oneself. In addition, social rejection can result in feelings of loneliness, which, in turn, may lead to psychological difficulties such as anxiety and depression.

### Psychological and Related Difficulties of Kids with LD

There are several psychological, emotional, and behavioral difficulties experienced by children with learning disabilities, according to the findings of a number of research studies. In the following list of problems experienced by kids with LD, the descriptions of research findings are carefully worded to indicate how strong the research evidence is for each problem. For example, research may only “suggest” some of the findings because there is a lack of conclusive evidence. For other problems, the word “shows” is used to describe findings because there is a group of studies that all come up with the same conclusion.

- Research has **shown** that individuals with learning disabilities **may experience** increased levels of **anxiety**.
- Research **suggests** that individuals with learning disabilities **may be** at greater risk for **depression**.
- Research **shows** that individuals with learning disabilities **experience** higher levels of **loneliness**.
- Research **shows** that individuals with learning disabilities **may have** a lower **self-concept (self-esteem)**.
- Research **shows** that individuals with learning disabilities **are at greater risk** for **substance abuse**.
- Research **suggests** that individuals with learning disabilities **may be at greater risk** for **juvenile delinquency** (there is some debate here).

As the parent of a child with LD, you may find this list a bit overwhelming, but don't panic. You are probably already taking many steps in your child's daily life — as described later in this article — to recognize, help prevent, or address psychological and behavioral issues associated with LD.

### How to Figure Out What the Research Means

Parents need to be especially alert when they read or hear news stories that report research results. Often, in an attempt to make stories more interesting and appealing, certain information may be overemphasized or presented in a sensational way, while other, more important information may even be omitted.

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In addition, although there is considerable research on the psychological and behavioral aspects of LD, not all studies are in agreement. For example, while some studies find a link between LD and juvenile delinquency, others do not. Differences in study results can be due to many things. In some cases, the studies may not define LD in the same way or may use different research methods (for example, interviews rather than statistical tests). Or, the studies may be looking at individuals of different age groups, socio-economic classes, or cultural backgrounds. Even the ways psychological problems are determined may differ between studies (for example, clinician observation rather than a standardized psychological test), which, in turn, may produce different results. So, it is important not to consider only the findings of a single study, but rather to look at the “collective findings” of many studies focusing on a specific area.

### Some warning signs of psychological difficulties

Low self-esteem is a common issue for kids with LD. Dr. Robert Brooks, a psychologist, Harvard Medical School professor, and expert on self-esteem, categorizes the signs of low self-esteem in kids as either “direct” or “indirect.” Direct indicators include words or actions that suggest that a child lacks self-confidence, is overwhelmed by challenges facing him, or has little hope for future success. At times, however, according to Dr. Brooks, signs of low self-esteem may be masked by a variety of self-defeating coping strategies, such as:

- **Quitting**, when tasks become difficult or frustrating;
- **Avoiding** a task or activity for fear of failing;
- **Clowning**, to hide lack of confidence or to relieve pressure;
- **Controlling**, to counteract a sense of helplessness;
- **Being aggressive and bullying**, to fend off feelings of vulnerability;
- **Denying**, in order to manage the pain they would feel if insecurities were acknowledged;
- **Being impulsive**, finishing tasks as quickly as possible “just to get it over with.”

“As an expert on your child's personality and typical behavior, you play a critical role in identifying early signs of possible problems.”

Occasional and short-term use of these unproductive coping strategies is probably not a cause for concern. But when they become the habitual way a child approaches daily tasks, interfering with learning, growing, and enjoying life, it's time to look at the feelings behind the behavior.

Some kids with learning difficulties may become either anxious or depressed as a result of ongoing academic and non-academic struggles related to their LD. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, which is used by physicians to diagnose psychological problems, a child who is anxious may seem worried most of the time; may act nervous in certain settings, such as in crowds of people, at school, or when expected to perform; or may fear being separated from home or from parents or other adults to whom he's attached.

A child who is depressed, according to *DSM-IV* criteria, seems sad or irritable most of the time; loses interest and pleasure in many activities she used to enjoy; over-eats or loses her appetite; feels inappropriate guilt; has trouble thinking, concentrating, and making decisions; feels worthless or hopeless. (Note: These are not complete lists of symptoms; only a qualified professional can diagnose anxiety or depression in your child.)

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If you are worried that your child may be experiencing psychological difficulties, discuss your concerns right away with your pediatrician, family physician, or a mental health professional. As an expert on your child's personality and typical behavior, you play a critical role in identifying early signs of possible problems. By taking action when you first notice that your child is having problems, you can begin to support her to regain her self-esteem, motivation, and the pleasure she gets from friends, family, and daily activities.

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### About the Author

**Linda Broatch**, Writer/Editor, has an MA in Education, with a focus in Child Development, personal experience in supporting those who have learning difficulties, and has worked for many years in nonprofit organizations that serve the health and education needs of children.





## A Parent's Guide to Psychological Problems

### What Research Tells Us about Depression in Children with Learning Disabilities

Depression can affect anyone, including children. It is one of the few conditions whose symptoms, such as feeling sad, have been experienced by most of us at some time in our lives. Who cannot admit to feeling “bummed out” in response to certain situations? Yet the clinical “syndrome” (a group of symptoms experienced together) of depression represents a disorder that can have a negative impact on almost all aspects of an individual’s life.

Children with learning disabilities (LD), in particular, have been the focus of almost 30 years of research on depression. When early studies were conducted in the 1970s, there were three reasons why children with LD were believed to be at greater risk for depression than children without LD:

- Children with LD often experienced low self-esteem, which is a symptom of depression.
- Children who were depressed tended to score lower on academic achievement tests, which is a defining characteristic of LD.
- Both children with LD and those who were depressed were believed to have some type of neurological disturbance.

“Children with LD were at no greater risk for experiencing severe depression than their non-disabled peers.”

Subsequently, researchers realized that low self-esteem and academic underachievement were conditions that affected many children, not just those who were depressed or those with LD. Also, **it has been very difficult to pinpoint specific neurological causes for both depression and LD.** Therefore, more accurate information was needed about the extent and impact of depression on children with LD.

Because public schools are mandated by law to provide services to children with LD, school was the logical place to begin looking at depression in these children. I began studying depression in children with LD in 1986. Through my research, and that of others during the 1980s and 1990s, it appeared that about 5% to 20% of children with LD experienced **symptoms of depression**. These figures were much higher than the acknowledged 2% rate for children without LD. But what the research didn’t tell us was whether children with LD experienced **clinical depression** at a rate higher than that experienced by the general population.

To answer this question, Bob Reid, my colleague at the University of Nebraska-Lincoln, and I collected every study conducted on depression in children with LD since 1977 when it became a federal category of disability. We reviewed 18 studies — all of which administered a “depression inventory” to children in the school setting. (Three of these studies were omitted because they didn’t meet important criteria for statistical analysis.) We reached three major conclusions from our review and analysis:

- Children with LD had statistically higher depression inventory scores than their non-disabled peers, but the magnitude of the difference between the two groups was not great.
- Children with LD were at no greater risk for experiencing severe depression than their non-disabled peers.

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- Factors other than having an LD, such as gender, age, and ethnicity may contribute just as much, if not more, to a child experiencing depression. (We know, for example, that far fewer females have LD than males.)

### Unanswered Questions about Depression and Children with Learning Disabilities

There are several areas in which we simply do not know the answer when it comes to depression and children with LD:

- We do not know if children with LD experience clinical depression in greater numbers than their non-disabled peers. The reason that these data haven't been collected is because a depressive disorder can only be diagnosed by a psychiatrist or psychologist after conducting a thorough clinical interview. The time involved and the number of clinicians required to administer clinical interviews to a large random sample of children with and without LD would be astronomical.
- We do not currently know what causes depression. Theories abound, but none are conclusive. In all likelihood, depression probably involves hereditary, neurological, and environmental components.
- We don't know exactly how accurately depression rating scales can predict whether a child with a high score would receive a clinical diagnosis of depression.

To explain the third point further, several commonly used paper-and-pencil rating scales or "depression inventories" are an important element of a clinician's diagnosis of depression. Most of these inventories are of the self-report variety. That means that a child is given a rating scale, reads the questions, and marks the one(s) that most accurately describes how he or she is feeling. Here is a sample item:

- 0 I am sad once in a while.
  - 1 I am sad many times.
  - 2 I am sad all the time.

After reading each item, the child circles the number (0, 1, or 2) next to the statement that best describes how he is feeling.

However, a **diagnosis of depression should never be made solely on the basis of a score from a rating scale** for at least two reasons:

- In some cases, there are no significant differences between the scores of children who are and are not depressed.
- There is a tremendous difference in scores even among children who have been clinically diagnosed as depressed.

In spite of this, these self-report rating scales have been the main way that information on depression among children with LD has been gathered. This fact raises further questions about the validity of the research to date on whether children with LD are more likely to be depressed than their non-disabled peers. **Parents should view critically, if not skeptically, most of the studies examining depression among children with LD.**

It's also important to note that, although research is inconclusive on several aspects of depression among children with LD, the news media often paint a very different picture. Parents may assume from what they read, hear, or see in the media that there is an indisputable connection between LD and



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higher rates of depression in children. As we know, news media are often interested in sensationalizing problems; they look for quick answers and rarely cover stories that contradict initial pronouncements. **This makes it very important for parents to be informed consumers and sift through the nonsense and hype that media can report on the problem.**

### Watch for Symptoms of Depression at Home and at School

My colleagues and I have advocated for years for parents who have children with LD to become familiar with the symptoms of depression so that any problems might be identified early on.

**Depression is much more than the occasional feelings of sadness that we all have from time to time.**

A person who experiences most or all of the symptoms listed below for more than two weeks can find it extremely difficult to face even the slightest bump in normal day-to-day activities.

Depression is a condition characterized by:

- extreme feelings of sadness
- lack of interest or pleasure in most or all activities
- significant weight gain or loss
- sleeping too little or too much
- restlessness or exhaustion
- low energy
- feeling worthless
- difficulty concentrating, and
- thoughts of suicide

Note: Only a qualified mental health professional can make use of these symptoms to diagnose depression in your child.

We've also advocated that schools take a greater role in identifying children with LD who may be depressed and developing ways to help them. Children spend more time in school than in most structured environments outside the home, and have their most consistent and extensive contact with teachers. Furthermore, children's behaviors, their interactions with others, and academic performance — all important indicators of mood and the ability to cope — are easily observed in school. Therefore, **it is not unusual for educators to be the first people to notice problems developing.**

However, as a parent, you need to stay in regular contact with your child's school and ask several important questions:

- Is my child making academic progress, performing about the same, or doing worse?
- Is my child interacting positively with others or is he withdrawing?
- Does my child appear to be happy during school or sad?

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- Does my child appear tired or seem to have adequate energy?
- Does my child seem to have a positive or negative attitude toward school?

A combination of answers to these questions that he is doing worse academically, withdrawn, sad, tired, and has a negative attitude are red flags that you should consider having your child evaluated for depression by a licensed clinician.

Remember, schools will not typically contact you when your child is having trouble in these areas. This is because children with depression do not usually engage in the acting out behaviors that would place them in conflict with the school. **You need to be proactive and persistent to get this information from schools — even if your child is receiving special education services.**

### What To Do If Your Child with LD Seems Depressed

Clearly, children with LD can and do experience depression. There are several things we can do to help them. The most important thing is to become familiar with the symptoms of depression and get your child in to see a psychiatrist or psychologist if you suspect problems are developing.

Once a diagnosis of depression has been made, there are several treatment options. The best option is usually a combination of medication and psychotherapy. You should also work in conjunction with your child's school for two reasons:

- Teachers can play an important role in identifying (but not diagnosing) children who may be depressed.
- If your insurance does not cover psychotherapy services or you cannot afford them and your child is receiving special education under the federal category of learning disability, he may be entitled to counseling as a related service under the Individuals with Disabilities Education Act (IDEA).

There is no reason for any child to suffer from depression when effective treatments are available. Through your efforts, and in conjunction with the school, your child can receive the treatment he needs and deserves.

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### About the Author

**Dr. John W. Maag**, professor at the University of Nebraska-Lincoln, specializes in the education and treatment of children and adolescents with emotional and behavioral disorders. A licensed psychotherapist, Dr. Maag has published over 80 articles and book chapters. Among four books he's authored, *Parenting without Punishment*, won a Parent's Choice award.



## A Parent's Guide to Psychological Problems

### How Parents Can Help Children Who Are Anxious

Children who cope with the daily frustrations and embarrassments of a learning disability (LD) may become excessively worried or anxious. A “vicious cycle” can develop, as the anxiety begins to make already difficult challenges with school and friendships even worse. What can parents do to prevent anxiety overload in their kids with LD? When anxiety begins to interfere with a child’s enjoyment of life, what can parents do to help?

To address these questions, SchwabLearning.org asked three clinical psychologists, with specialized background in counseling children with learning difficulties, to share their insights and advice with parents. Drs. Roberta Goldberg, Ken Herman, and Bruce Hirsch provide counseling for children and parents at the Frostig Center in Pasadena, CA. The center conducts research, provides professional development, and operates a day school for children in first through 12th grades with learning and attention problems.

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders™*, text revision, (DSM-IV-TR) devotes more than 50 pages to various kinds of anxiety disorders. For the purposes of this interview, we adopted a working definition of anxiety as: Excessive worry that is interfering with a child’s daily activities and/or his enjoyment of life. In this article, practical descriptions of excessive worry in children are provided as examples only, not as a means to diagnose an anxiety disorder in your child.

This is the second of two articles on the topic of anxiety among children with learning problems. In the first article, the three psychologists discussed some causes and symptoms of anxiety in children.

**When a child comes to see you because his parent — or teacher — is concerned about anxiety, what is your approach?**

**Bruce Hirsch:** The first thing I do, especially with an anxious child, is to go very slowly. Because if you immediately focus on their anxiety, you’re going to make the child more anxious. I try to create a very non-threatening environment. If they don’t want to talk much, that’s okay. They may want to do a little drawing instead, or play a game. Then I usually test the waters because all kids are different. I might say, “Gee, Mom and Dad said that you have a lot of trouble falling asleep at night, what do you think about that?” If the child withdraws at that point, I don’t push. Other kids may be relieved that someone’s finally addressing the anxiety so that they can talk about what’s going on.

When I work with kids, I always do the first appointment with Mom and Dad alone, so they can tell me things that might make the child embarrassed or uncomfortable if he or she were sitting there. So I’ve gotten a whole lot of information from the parents before I ever see the child — unless it’s a teenager, especially past 13 or 14, who would get suspicious if I met with Mom and Dad without them. Typically, when I talk to the child, I’m not gathering facts as much as I’m trying to get a sense of this child’s experience, what the world is like through his eyes.

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**Ken Herman:** Counseling with children and adolescents is not always a “front door” process. When a child is really anxious, we want to decrease the expectations around him, to support him, to help him feel confident in the resources that he brings to the table, and to help him work on self-soothing statements.

For one teenage boy, the counseling initially involved revisiting his psychoeducational assessment and then making reasonable expectations and accommodations for him. The family and I decided family therapy would be the best approach to help this adolescent with his anxiety symptoms. He was involved in the decision and he indicated he might feel too vulnerable and “strange” in individual counseling. It seemed he was feeling anxious and intimidated about the counseling and sought his parents’ protection and support if he was going to discuss his learning and attention problems. This brought his emotions into the room and was a great discussion point later in the therapy. We recalled later how anxious he was at the start of counseling, and we worked to enhance his coping skills and decrease stress in a number of ways. We increased his awareness of his own internal resources, increased his social support network, enrolled him in a karate class, helped him maintain perspective and not catastrophize situations, increased compartmentalization skills, improved time management and organization skills, and worked toward independence in many different ways to help him feel competent and in control of his life.

“When a child is really anxious, we want to decrease the expectations around him, to support him, to help him feel confident in the resources that he brings to the table, and to help him work on self-soothing statements.”

### What are some ways within the home and family that parents can help a child manage anxiety?

**Roberta Goldberg:** One of the things parents need to do, especially in the 2nd to 6th grade period, is take care of themselves. They’ve got to have respite. This is a good time to get some counseling for parents **and** children, to help them navigate this time, so that they can respond to their children’s frustrations, struggle through a couple of hours of homework, yet still have the strength to get dinner on the table.

It’s important to introduce “strengths and weaknesses” into the family vocabulary — the idea that everybody in this family has some things they’re very good at and things they **aren’t** so good at. So, the youngster who’s got learning disabilities — who’s got, say, serious weaknesses in reading comprehension — also has some strengths in soccer or piano playing or packing the car for the camping trip. With this approach, this child doesn’t stick out as the only one in the family who doesn’t do well.

**Bruce Hirsch:** Most importantly, parents can do something that I never do with clients and that is to hug and cuddle their kids. I think physical touch is extremely important for soothing anxiety. One of the first questions I talk about with parents is how their child accepts physical touch. We do have some kids who, for whatever reason, shy away from too much physical touch, but that’s really a minority. I think as touch gets internalized, it feeds into self-soothing, which is such an important part of dealing with anxiety.

**Roberta Goldberg:** When kids with learning disabilities start middle school, I think we need to scaffold them. A lot of parents think, “They’re in middle school; they ought to be able to take care of all this.” Well, often they aren’t taking care of all of this and they’re failing. So I help parents to realize that, although they **wish** their youngster was an independent learner, they are not yet. And if we don’t

## How Parents Can Help Children Who Are Anxious

provide them with some of the scaffolding — like helping them plan and organize — we're deluding ourselves.

I am not opposed to parents typing for children, with the teacher's knowledge. But they have to type exactly what the child has written. It has to be thought of as an accommodation. This is a controversial opinion, but I think the parents' job at this stage is to do everything they can to help children develop the compensatory skills required to show what they know.

Parents should also keep a keen eye on a young adolescent's social interactions. One of the primary anxieties reported to us in our longitudinal study for middle school was social anxiety. And that is the fear that their learning disability will be discovered by their friends and that they will not be considered cool. Parents need to shift the balance more toward "private," clandestine remediation, and away from noticeable, or "public," remediation.

Are there approaches or actions parents should avoid in dealing with an anxious child?

**Ken Herman:** If you're being the disciplinarian or if you're too invested in the homework getting done, then you lose the most important role for a parent to play. Ultimately, the child needs you as their parent, not as their tutor. They need you to love them no matter what. They need to cry and have you hold them and pat their head and say, "It's okay, honey; I know it's hard." Even if they fail a test, even if they can't do a single problem on that "stupid page," they need you to love them. They need to know it's okay, that you believe that they've made their best effort. And that tomorrow's another day, and we'll get up and try it again.

**Bruce Hirsch:** Avoiding catastrophic thinking is a big one, especially because we're often dealing with parents who are very anxious themselves. The thing I see repeatedly — and parents don't necessarily like me to address this issue, but I do — is kids getting a couple of poor grades in a highly pressured academic environment, and the parents saying, "If you fail this class, you will never get into a decent college and you will never get a decent job." And I think, whoa! I know it would be better if you passed this class, but one failure or even being retained, these are never the absolute end of the world. So I really try to put that kind of catastrophic thinking back into perspective.

If parents have found particular things that are helpful to them in dealing with anxiety — whether it's yoga, meditation, deep breathing, visualization — I think it's great for them to teach those to their kids, and to do them together. Exercise is really important in both anxiety and depression control. Families can go out bicycling or jogging together.

**Ken Herman:** There's way too much pressure on children. We expect them to go to college and become professionals — doctors and lawyers and such. It's not that a child with learning disabilities can't do that. But parents have to allow for a variety of post-high school options.

Each child is an individual, and it's okay not to go to college. It's okay to go into employment or go to a trade school or do something else. It's also okay to go to college when you're 30 or whenever you have better self-discipline and are better organized. Unfortunately, even if the family adjusts its expectations, children go to school and they get the pressure from their peers, especially in high school: "What's your GPA?" "Where are you going to college?"

“The child's psychological and emotional well-being is the number one objective, and we can't lose sight of that ... Pushing beyond our limits only leads to anxiety and school burnout ... ”



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## How Parents Can Help Children Who Are Anxious

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### What are some ways that parents and teachers can cooperate in monitoring and addressing anxiety in kids with learning difficulties?

**Bruce Hirsch:** Teachers are actually very good at figuring this out because veteran teachers typically see lots of kids over many years. So, they have lots of points of comparison. I sometimes consult with teachers at The Frostig Center to get a better sense of how anxious a kid is. Parents have a much harder time of it, even if they're very sophisticated, because typically today's parents are having one, two, maybe three kids. So there's not a lot of comparison. Sometimes a parent's point of comparison is the self. And anxiety, like many psychological characteristics has a large inherited component to it. So, often parents will say: "This child reminds me of myself at this age. But I struggled alone with this, and I'd like my child to have some help."

**Roberta Goldberg:** Kindergarten teachers are great communicators. They usually send home information. Even if you think that your youngster is not doing too well in pre-reading and pre-math areas, for example, if you get the sad face when they're telling you what they learned about numbers and letters, I wouldn't jump to any conclusions until January of kindergarten year. I would resist any reaction or response that would give the child an indication that **you're** nervous that they're not getting it, or that **you** don't have confidence that they are going to get it. We really have to rely on the kindergarten teacher's wisdom and experience with seeing lots of young children starting down this path of learning to read.

**Ken Herman:** We know that learning difficulties are a lifelong issue. Coping with them is a marathon; if you start sprinting, you're not going to make it. For example, the daily grind of the homework and the daily fights about it do not have to happen. Children with learning disabilities are of at least average intelligence; they **are** going to learn. What I encourage a lot of parents to do is — every night when their child starts decompensating around the homework — to draw the line and write a note to the teacher that says, "We did what we could do; done." Because the child's' psychological and emotional well-being is the number one objective, and we can't lose sight of that. While I firmly believe that students with learning disabilities and attention disorders need to learn perseverance in the face of challenge, I also know that this lesson is learned over years and that we can only persist to the extent of our daily attentional and emotional capacity. Pushing beyond our limits only leads to anxiety and school burnout, among other problems.

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### About the Author

#### Frostig Center Colleagues

**Roberta J. Goldberg, Ph.D.**, is Director of Consultation and Education at the Frostig Center in Pasadena, CA, managing outreach and teacher training in local schools.

**Kenneth Herman, Ph.D.**, a member of the clinical and research departments at the Frostig Center, is also founder and CEO of a private clinical practice.

**Bruce Hirsch, Ph.D.**, Director of the Clinical Department at the Frostig Center, also works in private practice and in a multidisciplinary psychological services group.



## A Parent's Guide to Psychological Problems

### Anger Overload in Children: Diagnostic and Treatment Issues

Anger reactions in some children are quite frequent and troubling to parents and teachers who witness them. The child's intense anger may erupt quickly and intensely in reaction to limit setting by adults, to teasing or to seemingly minor criticism by peers or adults. **This is a distinct psychological problem in children which is separate from diagnoses such as attention-deficit/hyperactivity disorder, bipolar disorder, and oppositional defiant disorder.** It can co-occur with AD/HD or learning disabilities, but may also occur separately from these diagnoses.

At this time, the diagnostic manual, *DSM-IV\**, does not consider anger disorders as a separate category like depression and anxiety. However, many mental health professionals feel it is a category unto itself and are devising treatment strategies for anger problems. Daniel Goleman (in *Emotional Intelligence*) and John Ratey and Catherine Johnson (in *Shadow Syndromes*) offer cogent reviews of this literature. Goleman uses the term "anger rush" to describe anger problems in adults, while Ratey and Johnson refer to a shadow syndrome for "intermittent anger disorder" in adults. Anger disturbances in children need to be classified as a discrete psychological problem as well, and they require particular treatment strategies. This article defines the syndrome and outlines effective treatment strategies.

“With anger overload, the child becomes totally consumed by his angry thoughts and feelings.”

#### Diagnostic Issues

The term "anger overload" is used to refer to the intense anger response which has been the presenting problem for a number of young children and preadolescents seen in a suburban outpatient practice. **There is an intense and quick reaction by the child to a perceived insult or rejection. The rejection can seem quite minor to parents or others.** For example, a parent saying "no" to something the child has been looking forward to doing can trigger an intense period of screaming and sometimes hitting, kicking or biting. Another common situation which can trigger anger overload may occur in a game with peers. It can involve a disagreement on how the game should be played or its outcome. Parents often explain to the mental health professional that these reactions have been going on since early childhood in one form or another. It is frequently reported that these children become sassy and disrespectful: they will not stop talking or yelling when they are upset. At other times, when their anger has not been stimulated, these children can be well-mannered and caring.

The problem is called **anger overload** because it is more severe than a temporary anger reaction lasting only a few minutes. With anger overload, the child becomes totally consumed by his angry thoughts and feelings. He or she is unable to stop screaming, or in some cases, acting out physically, even when parents try to distract the child or try to enforce limits and consequences. The anger can last as long as an hour, with the child tuning out the thoughts, sounds or soothing words of others.

Another significant characteristic is that these children are sometimes risk takers. They enjoy more physical play than their peers and like taking chances in playground games or in the classroom when they feel confident about their abilities. Other children are often in awe of their daring or scared of their seemingly rough demeanor. Perhaps most interesting is that these very same risk takers can be

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unsure of themselves and avoid engaging in other situations where they lack confidence. A number of these children have mild learning disabilities, and feel uncomfortable about their performance in class when their learning disability is involved. They prefer to avoid assignments where their deficits can be exposed, sometimes reacting with anger even if the teacher privately pushes them to do the work with which they are uncomfortable.

One diagnostic fallacy is to assume that these children have bipolar disorder. Dr. Dimitri and Ms. Janice Papolos recently devoted a full book to the disorder (*The Bipolar Child*, 1999). **The rages of children with bipolar disorder are more intense and lengthy than for the children we are currently discussing.** The Papoloses describe (page 13) that for children with bipolar, these angers can go on for several hours and occur several times a day. In children with bipolar, there is often physical destruction or harm to something or someone. In children with anger overload, the outburst is often brief, less than half an hour, and while there may be physical acting out, usually no one is hurt. In addition, children with bipolar have other symptoms such as periods of mania, grandiosity, intense silliness, or hypersexuality.

Anger overload is also different from attention-deficit hyperactivity disorder. Children with AD/HD have significant distractibility, which occurs regularly in school and/or the home. By contrast, children with brief outbursts of anger often pay attention well when they are not “overheated” emotionally. In addition, children with AD/HD may have hyperactive movements throughout the day; whereas children with anger overload only seem hyperactive when they are overstimulated with feelings of anger. Finally, children with AD/HD are often impulsive in a variety of situations, many of which have nothing to do with anger.

It is possible, however, for children to have symptoms of AD/HD and anger overload. This combination is especially difficult for parents to manage. Behavioral strategies for AD/HD are not as effective because the child becomes excessively angry despite efforts by others to focus his attention elsewhere. Sometimes, professionals then tell the parents or teachers that they are not applying behavior modification techniques properly. **What may work for a child who has AD/HD may not be as effective for a child who also has the problem of anger overload.**

Another diagnostic category which can be differentiated from anger overload is oppositional defiant disorder. **Oppositional children have a continuing pattern of disobedience to adult demands, whereas children with anger overload are only defiant when their anger is stimulated.** The situations which trigger their anger are more restricted. There are certain areas which have special importance to them, such as winning a game, buying a toy or being seen as successful in school. In most other situations, they are described by their parents as sweet and cooperative. Few, if any, oppositional defiant children are described by their parents in this manner.

### Treatment Techniques: Behavioral Strategies

When these children first come to a professional's attention, there may be a tendency to think that the parents must learn to ignore their children's tantrums. But this will not work reliably for children with anger overload. Their angry outbursts will not be extinguished this way. Behavior therapy for these children involves working with the parents as much as, or more than, the children themselves. Parents and teachers can learn strategies to teach their child self-control in a shorter period of time than the therapist can teach the child alone. By coaching the parents, the therapist has an impact on the child throughout the week. In addition, children cannot apply therapeutic strategies themselves at home when the anger is building. They need someone to cue them on what to do — usually a parent or teacher.

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The first strategy is for the adult to recognize *when* the child is about to experience anger. This is sometimes difficult for anyone to predict. However, **over time, parents and teachers begin to recognize signs that an angry outburst is impending**. The look in the child's eyes, the tone of his voice or the tightness in his body tell the adult that the child is beginning to get upset. The time from when the child gets upset to when he shows full-blown anger may only be a few seconds. If it is caught in time, the child is much more likely to achieve self-control than if the adult tries to intervene once the child is overflowing with emotion. It is as if the child's brain has reached overload then, and it takes some time to cool off.

One technique to use before reaching this point, is distraction. The parent should try to turn the child's attention to something else that is interesting to him/her. It is important that the distraction be interesting to the child — something he/she likes and that involves some action. The child is unlikely to immediately choose a quiet, sedentary activity like reading. A more effective distraction technique is going outside to ride a bike or playing catch. For example, if the family is at a park and the child does not want to leave the swings, then suggest he try the slide — which is an activity with a more natural ending point. Once he comes down the slide, the activity is at a possible stopping point. That is a good time to direct him to the car.

**To help motivate the child, some behavior modification mechanism should be in place.** Choose incentives and consequences that are brief and preferably immediate. A colorful chart or poster can be used to track two or three behaviors which the child needs to demonstrate during the day in order to earn a reward. Select one or two behaviors and review a behavior plan for these situations with your child.

The basic principle is to offer an **alternative behavior** that is more socially acceptable than an angry reaction. If the child does not use the alternative behavior, and moves into a rage, a negative consequence may be imposed. The principle for negative consequences is similar to rewards: brief and immediate, where possible. **A brief consequence such as being grounded from going outside and/or playing computer games for a few hours (or up to a day long, depending on the severity of the offense) is helpful in getting the child to recognize the importance of using self-control.** If, instead of using a strong verbal response, the child hits back when teased, a consequence will send a message better than trying to talk to the child. Children take consequences more seriously than "lectures." They are more likely to remember a consequence later and to choose a more appropriate response the next time. Parents need to be firm about applying negative consequences because they send an important signal to the child. While such enforcers do not help shorten the immediate anger, they can help lower the frequency of angry outbursts in the future.

**Another key principle when applying negative consequences is to eliminate discussion at the moment the child is raging.** Giving the child attention, even talking, is a reward for negative behavior. Plus, the child who is raging is not rational at the moment, and the rage is likely to escalate further if consequences are mentioned while he is having a meltdown.

### Therapy for AD/HD and Anger Overload

If the child also has AD/HD, problems like distractibility in the classroom or failure to complete assignments cannot be effectively dealt with until the child learns how to control his angry reactions. Otherwise, the child will likely react with extraordinary anger when teachers or caregivers give consequences or time outs for not working on or not completing class work. The child may feel criticized or embarrassed and not know how to control these feelings. **Once anger control is learned, behavior modification aimed at goals like completing assignments is much more effective.**

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The issue of medication for AD/HD has also been problematic at times for children who simultaneously have anger overload problems. Sometimes, stimulant medication will work for both problems, but it can also make it harder for a child to control his anger. In that case, medications other than stimulants should be considered. In some cases, a combination of a low dose of SSRI medication along with a low dose of stimulant medication can be helpful. However, the issue of medication for the dual problems of AD/HD and anger overload needs further study.

### Cognitive Treatment Strategies

One important point which affects how a child responds to a provocation is **the way he or she perceives the problem situation**: does he feel embarrassed, humiliated or rejected? If the child feels an insult to his sense of pride, or feels as if he was treated “unfairly,” he is more likely to exhibit rage. **Teaching the child to respond assertively but in a controlled manner helps him not to feel humiliated or put down.**

This approach is similar to cognitive therapy approaches, which aim to change the way a person experiences a situation. Sometimes the parent or therapist can suggest to an older child another way to look at the intentions of the other by whom the child feels put down. This is not always effective, as many children will insist on their interpretation of the situation. Instead, the adult helps the child to respond differently so that the child then “feels” differently about herself. By being assertive or learning new social skills, the child is less likely to feel embarrassed and upset.

**Teaching the child one catch phrase is an effective cognitive strategy that can be used.** For many children, one such phrase is, “everyone makes mistakes.” Children with anger overload often have high standards for themselves without even realizing it. They generally are not obsessive-compulsive by nature, but they also lack the social sense about what normal expectations are for children their age.

For example, one child frequently got upset when he made a written mistake in school. Another child raged when he could not find a puzzle piece, and another when his team lost a baseball game. **Teaching these children that “everyone makes mistakes” really helps.** They learn to say this phrase to themselves at the time of a mistake. Often we role play this scenario ahead of time in the therapist's office. This strategy, like the others we've discussed, takes time to work. The child may not remember to use it when he or she is upset, and once it is finally used, may forget it altogether. But over time, it will become more automatic.

Another useful phrase to use is, “Is this a good risk?” Since children with anger overload are often risk takers, they like to try new challenges, including those that are dangerous or likely to provoke a negative response from adults. One child liked to make jokes in class when someone made a “funny” mistake. His classmates would laugh louder, and the teacher would get angry and give him a consequence. The child felt this was unfair and reacted with anger. The therapist helped the child to see the cause and effect of his actions, and taught the child to evaluate the risk before making his remark. The child also learned to let others take chances and make funny remarks, rather than always taking the lead and getting punished.

**Nonverbal cues can also be effective in some situations.** A nonverbal cue, such as the adult putting up his hand like a policeman does to stop traffic, is more likely to work when the child is becoming upset rather than moving toward a full-blown rage. Also, the signal needs to be prearranged with the child when he is calm in order to increase the chances that the child will see the signal as benign, not as a punishment.

“ Parents and teachers can learn strategies to teach their child self-control in a shorter period of time than the therapist can teach the child alone. ”

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### Future Research Ideas

For parents, a key factor in working with angry children is patience and practice. The techniques described above take time for parents and children to learn. The child's problems are probably related to developmental lags or to subtle neurological deficits. In *Emotional Intelligence* (1995), Daniel Goleman summarizes research with adults which suggests that the limbic system of the person's brain goes into overdrive when anger occurs, causing catecholamines to release. One neurological hypothesis which needs further testing for children with anger overload is whether there is a lag or deficit in their limbic systems, so that catecholamines are released more quickly or in higher concentrations than for other children. Building new behavior patterns is possible, but again takes time. **Parents should notice gradual improvements towards the goal of self-control rather than feeling defeated if there is not an immediate change.** It is not the parent's fault if the child has problems with anger. Often if the parents review their family trees, they will notice some other relative, if not themselves, who had difficulty with anger as a child. In many cases, there most likely is a genetic component. This is not to say that anger overload cannot be changed. Internal mechanisms for self-control can be learned by the child. But the approach must be methodical and requires extreme patience. Parents will feel relieved once they begin using strategies that work and realize that their children are not destined to a lifetime of anger overload.

*\*The "DSM-IV: Diagnostic and Statistical Manual of Mental Disorders-IV," published by the American Psychiatric Association is the standard reference source for mental health professionals.*

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### About the Author

**David Gottlieb, Ph.D.**, received his B.A. in the area of developmental psychology from Harvard College and his Ph.D. in clinical psychology at Northwestern University. Dr. Gottlieb is in full-time private practice in the South suburbs of Chicago and has also taught a family therapy course at Governors State University.





## A Parent's Guide to Psychological Problems

### How to Help a Child with Learning Disabilities Who is Lonely

Children with learning disabilities (LD) are more likely to be lonely than kids without LD. A growing body of research shows that many children with LD face considerable challenges in making and keeping friends. Fortunately for parents of children with LD, research studies also offer some guidance about effective approaches to help children cope with or avoid loneliness.

In this article, the second of two on the topic of loneliness among children with LD, we present the research findings of Dr. Malka Margalit, Head of the Constantiner School of Education at Tel-Aviv University in Israel, who has studied loneliness among children with LD for more than 20 years.

The first article, "Loneliness Among Children with Learning Disabilities" addressed the questions:

- Why are children with LD more likely than their peers to be lonely?
- How do children with LD experience loneliness?
- What are some particular social and emotional characteristics of lonely children with LD?

In this article, we summarize some of Dr. Margalit's research on:

- Loneliness among elementary school kids and adolescents
- Characteristics of kids with LD who are **not** lonely
- Effective approaches to helping the child with LD cope with or avoid loneliness.

“When parents share with children the challenges they face in cultivating and maintaining friendships, children gain the hope and motivation they need to cope with their own social difficulties.”

— Dr. Margalit

#### Loneliness among Elementary School Children with LD

When researchers study popularity and friendships in school settings, they often ask children to name several kids in their class they like and several they dislike. When two children name each other as a person they like, researchers refer to them as “identified friends.” Likewise, two kids who name each other as a person they dislike are termed “identified enemies.”

Using the identified-friend/enemy survey, Dr. Margalit's research<sup>1</sup> revealed that, within the group of **children with LD**, those who had at least one “identified enemy” in the class felt lonelier than kids with LD who had no identified enemies. However, among the **kids without LD**, those with an identified enemy did **not** feel lonelier than kids without an identified enemy. This finding reveals, Dr. Margalit says, the social and emotional vulnerability of students with LD, who, because they often have such limited social networks, attach greater importance to the negative attitudes of other kids toward them. In general, research shows that children with LD are more likely to experience social stresses such as loneliness, and are less likely to have the internal resources to cope effectively with them.



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Interestingly, one of Dr. Margalit's studies indicated that computer use predicted lower levels of loneliness for kids with LD. "We need to look more closely at whether children's use of the Internet will challenge our traditional views of understanding what loneliness and friendship are," Dr. Margalit commented. "Sometimes we are biased against technology, worried that children may neglect their face-to-face friendships in favor of virtual connections. I would like to encourage parents to think differently about e-friends and Web peers, since they may expand children's social networks, enable them to try out their social skills, as well as give them a different sense of their social status."

### Loneliness among Adolescents with LD

Dr. Margalit conducted another study<sup>2</sup> to determine whether social environment would have any impact on the prevalence of loneliness among teenagers with LD. She and her colleagues compared rates of loneliness between a mixed (with and without LD) group of teens living in an urban environment, and a comparable group of teens living on an Israeli kibbutz. Because the kibbutz is a highly communal living arrangement, some researchers predicted that kids with LD in this environment would be less likely than the urban kids with LD to experience loneliness. This was not the case. In fact, this and other studies showed that, across age and social setting, teenage kids with LD consistently reported higher levels of loneliness. They were also rated by their teachers as less socially adjusted, and by their peers as less accepted.

### Not All Children with LD Are Lonely

In several studies of loneliness among children with LD, according to Dr. Margalit, a small group of kids with LD was identified who were **not** more likely to view themselves as lonely or socially distressed than were their peers without LD. Using a research approach that emphasizes identifying kids' strengths, Dr. Margalit identified two characteristics common to the children with LD who were **not** lonelier than their peers without LD:

- They had age-appropriate social skills.
- They had average scores on a survey that measures "sense of coherence."<sup>3</sup>

A child with a strong sense of coherence views the world both within and outside himself as ordered and predictable. When this child faces a problem, such as feeling isolated and out of touch with classmates, he is able to assess the problem and choose, from among a repertoire of social skills, an appropriate strategy to address it. For example, he might strike up a conversation with a classmate, using the strategy of identifying a mutual interest such as a recent movie, a television program, or a new computer game. Or the child might develop social relationships outside school, either in his neighborhood or through a hobby or a leisure activity that involves contact with other children.

### Helping Children with LD Overcome Loneliness

Dr. Margalit cautions that parents may sometimes feel anxious while trying to help their child cope with loneliness. A child's despair may bring back unpleasant memories of their own childhood experiences of loneliness. Dr. Margalit encourages parents to be aware of two important things:

- Because they are role models for their child's social behavior, they should reflect on and converse with their kids about their experiences in current and childhood friendships.
- Parents can also model self-awareness and reflection on the positive and negative emotions associated with friendships.

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"When parents share with children the challenges they face in cultivating and maintaining friendships," Dr. Margalit says, "children gain the hope and motivation they need to cope with their own social difficulties."

Effective approaches to helping children with LD to overcome loneliness, according to Dr. Margalit, require both a carefully structured social environment and close attention to each child's particular social skills and challenges. With the overarching goal of empowering the child with LD to improve his social relations with peers, Dr. Margalit emphasizes that successful interventions rely on a combination of approaches. Among these are:

- **Becoming knowledgeable about your child's social life.** Observe your child's social behavior to determine specific strengths and weaknesses. For example, you might compare your child's behavior in initiating and maintaining social contacts with those same behaviors among his peers. You might want to check your observations against those of your child's teacher or coach, as well.
- **Structuring the environment to promote friendship and satisfactory relationships among kids,** to provide them opportunities to experience social competence. For example, you might set up an opportunity for a lonely child to work collaboratively with another child on a task or project, being careful to select a child who is likely to work well with your child, and a task that they can successfully complete. Let your child's teachers know that you are working with your child on friendship skills. The teacher can then structure the classroom environment to support his efforts to form satisfying social connections with classmates.
- **Providing training and intervention to promote children's competence and sense of control.** During Dr. Margalit's study, children had the advantage of practicing social skills in the context of carefully structured training activities. To help children "transfer" these skills from the training sessions to the "outside" world, adults engaged children in conversations about how the social situations they faced in the training were similar to those in their lives. Individual children were asked to try out a particular social task in a real-life situation and report back on how it worked. The results were "quite promising," Dr. Margalit says. Children became more active in initiating social contacts and planning social activities, and became less impulsive and less rejecting during social exchanges. Different types of social skills training were found to be effective:
  - o Modeling
  - o Peer tutoring
  - o Role-playing
  - o Problem-solving exercises

Problem-solving exercises were based on typical social scenarios that researchers developed based on children's own reports of social challenges and disappointments. For example, "Dan sees his friends heading for the computer lab to play games, but Dan is not invited." Children were asked, "If you were Dan, what could you do?" Children were asked to map out different options, evaluate the pros and cons of each, and choose one course of action. Predictably, some children suggested aggressive responses ("Yell at the kids!"), and others suggested passive responses ("Just don't talk to them."). Some kids suggested age-appropriate strategies such as inviting the group of kids to play a new computer game, or getting together with another child who wasn't invited to join the activity.

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- **Nurturing a child's belief in his ability to develop better friendship skills.**<sup>4</sup> For a child to cope effectively with stressors in his life such as loneliness, he requires ongoing empathy, encouragement, and problem-solving support from adults in order to:
  - View friendships and satisfying social relations as important.
  - Develop the hope and motivation to persist in making friends.
- **Maintaining a positive attitude and accepting that kids may vary in the way they form friendships.** You may feel sometimes that the social relationships your child is developing are childish or superficial or that your child's friends are too young or not really a good match. By understanding that friendship skills take time and practice, you will be able to give your child the encouragement and support he needs to build these skills in his own way and at his own pace.

Loneliness is distressing for anyone. For a child with LD, loneliness may become an ongoing struggle, resulting from a lack of social skills, or a belief that he cannot make and keep friends. As a parent, you can play an important role in identifying your child's specific social strengths and challenges, and helping him understand that friendships require effort and skill. By doing so, you support his hopes for closer friendships and more meaningful social networks in the future.

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### Featured Researcher

**Malka Margalit, Ph.D.**, Head of the Constantiner School of Education at Tel-Aviv University, is professor of education and an internationally recognized expert on loneliness in children, and on the empowerment processes of children with learning disabilities. In her research she examines emotions, motivation and adaptive development. She serves on the editorial boards of several journals, among them the Journal of Learning Disabilities and Exceptional Children.

### About the Author

**Linda Broatch**, Writer/Editor, has an MA in Education, with a focus in Child Development, personal experience in supporting those who have learning difficulties, and has worked for many years in nonprofit organizations that serve the health and education needs of children.



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### Resources & References

#### Learning Disabilities and Psychological Problems – An Overview

##### Books

Raising Resilient Children

<http://www.amazon.com/exec/obidos/tg/detail/-/0809297655/>

By Robert Brooks and Sam Goldstein

When You Worry about the Child You Love: Emotional and Learning Problems in Children

<http://www.amazon.com/exec/obidos/ASIN/0684832682/>

By Edward M. Hallowell, M.D.

##### Websites

National Institute of Mental Health Website

<http://www.nimh.nih.gov/>

The Frostig Center:

Life Success for Children with Learning Disabilities

<http://www.ldsuccess.org/>

#### What Research Tells Us about Depression in Children with Learning Disabilities

##### Website

samgoldstein.com:

Lonely, Sad, and Angry: How to Know If Your Child Is Depressed and What to Do

<http://www.samgoldstein.com/template.php?page=postings&type=articles&id=4>

SchwabLearning.org:

How Parents Can Help Children Who Are Anxious

<http://www.schwablearning.org/articles.asp?r=784>

##### Books

It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents

<http://www.amazon.com/exec/obidos/tg/detail/-/0812929217/>

By Harold S. Koplewicz, MD

##### Video

Look What You've Done! Stories of Hope and Resilience for Teachers and for Parents

<http://www.drrobertbrooks.com/products/index.html#dvd>

By Dr. Robert Brooks

##### References

"Social Skills Deficits and Learning Disabilities: A Meta-analysis,"

by K.A. Kavale and S. R. Forness, in the *Journal of Learning Disabilities*, 1996, Volume 29, pages 226-237.

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## Resources & References

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#### Books

Emotional Intelligence

<http://www.amazon.com/exec/obidos/ASIN/0553375067/>

By Daniel Goleman

The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder

<http://www.amazon.com/exec/obidos/ASIN/0767903161/>

By Dimitri and Janice Papolos

Shadow Syndromes

<http://www.amazon.com/exec/obidos/ASIN/0553379593/>

By John Ratey and Catherine Johnson

The Explosive Child

<http://www.amazon.com/exec/obidos/tg/detail/-/0060931027/>

By Ross W. Greene, PhD.

#### Websites

Children and Adults with Attention Deficit Disorder (CHADD) website

<http://www.chadd.org/>

U.S. Department of Health and Human Services:

Helping the Child Who is Expressing Anger

<http://www.mentalhealth.org/publications/allpubs/Ca-0032/default.asp>

Virginia State University:

Dealing With the Angry Child

<http://www.ext.vt.edu/pubs/family/350-021/350-021.html>

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#### References

This article is based on excerpts from: Margalit, M. & Al-Yagon, M. (2002). "The loneliness experience of children with learning disabilities." In B. Y. L. Wong & M. Donahue (Eds.). *The social dimensions of learning disabilities* (pp 53-75). Lawrence Erlbaum, New Jersey.

Full citations of the following studies referenced in our article appear in the book chapter (cited above) on which the article is based (Margalit & Al-Yagon, 2002).

1. Margalit, Tur-Kaspa & Most, 1999
2. Margalit & Ben-Dov, 1995
3. Antonovsky, 1979; 1987
4. Rizzo, 1988