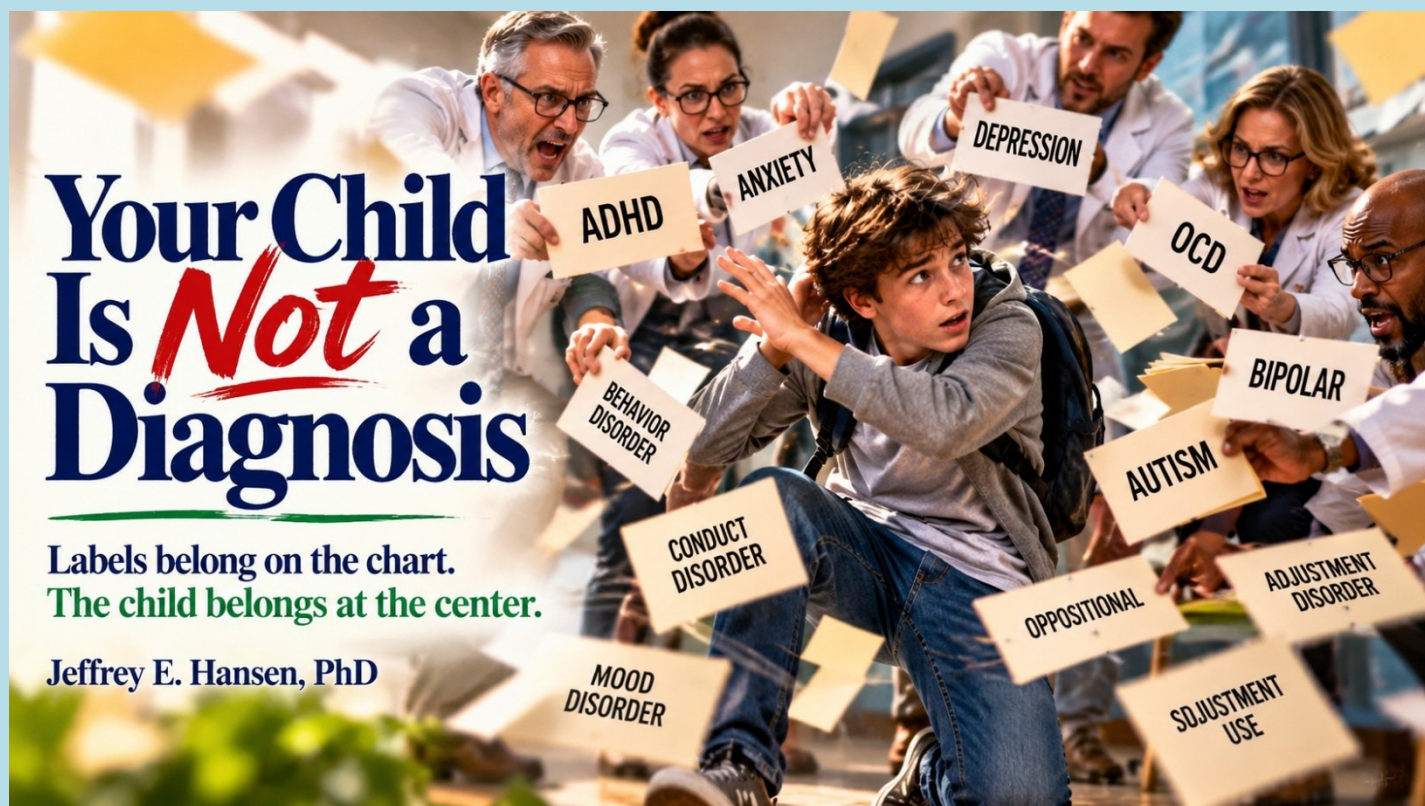




Labels, Labels, and More Labels

I appreciate a good label. When I pick up a candy bar, I want to know what is in it. If someone has packed the thing with enough sugar to launch a small rocket, I would prefer to find that out before I eat it. And if a child has a serious food allergy, an accurate ingredient label can be lifesaving. Labels are not the enemy. They tell us something useful about what we are dealing with.

But children are not candy bars. They are not products to be sorted, coded, and shelved. Yet somewhere along the way, medicine and mental health have become awfully comfortable treating them as if the label were the most interesting thing about them. We evaluate a struggling youngster, identify a symptom cluster, enter a code, construct a treatment plan, and sometimes begin speaking as though the code has explained the child. Congratulations: the paperwork is complete. Has anyone actually met the kid?

I have spent roughly four decades working with children and adolescents, including years in pediatric psychology, military medicine, teaching, and clinical supervision. I love these kids. I love their curiosity, their outrageous humor, their capacity to recover, and even their occasional ability to drive every adult in a fifty-mile radius completely nuts. I have sat with frightened children, exhausted parents, and teenagers who cannot imagine that life might become something better than the mess they are in today. They deserve every good tool our professions can offer. What they do not deserve is to have their lives reduced to the most convenient description of their difficulties.

Let me be unmistakably clear: I believe in diagnosis. Depression can be devastating. ADHD can create real impairment. Trauma can profoundly disrupt development, relationships, attention,

and the experience of safety. Failing to recognize those problems would be negligent. But recognizing a disorder is the beginning of understanding, not the end. The moment a child begins introducing herself to the world as “Sally, otherwise known as major depressive disorder,” I start getting a little hot under the collar. Something has gone wrong when the label moves from the medical record into the center of the child's identity.

The DSM Did Not Come Down From Mount Sinai

I respect psychiatry. I have worked with extraordinary psychiatrists, and I know the difference careful diagnosis and effective treatment can make. But respecting a profession does not require kneeling before its manual. The Diagnostic and Statistical Manual of Mental Disorders is a human-made classification system, not a set of stone tablets delivered from heaven. The American Psychiatric Association's history of the DSM describes a series of revisions intended to improve clinical communication and classification (American Psychiatric Association, 2026a). Those are legitimate goals. Let us not confuse them with infallibility.

DSM-III arrived in 1980 with more explicit criteria and an admirable determination to improve reliability. If two clinicians examine the same child, it helps enormously if they can speak the same diagnostic language. But how were the categories and criteria decided? Through professional deliberation, negotiation, consensus, and, at times, voting. Yes, voting. Davies (2017), drawing on archival materials and interviews with DSM task force members, documented the role of voting and consensus in DSM-III and DSM-III-R decisions. I have sat on enough committees to know they can accomplish wonderful things. I have also sat on enough to know that a collection of highly educated people around a table does not automatically produce biological truth. Sometimes it produces wisdom. Sometimes it produces compromise. And sometimes it produces whatever everybody can agree on before lunch.

A vote can establish a convention. It cannot vote a disease into existence. Reliability, our ability to agree on a classification, is not the same thing as validity, whether that classification accurately captures a distinct phenomenon in nature. The National Institute of Mental Health (2017) has itself questioned the assumption that conventional psychiatric syndromes are equivalent to discrete diseases. Its Research Domain Criteria initiative explores dimensions of functioning that cut across diagnostic boxes (National Institute of Mental Health, n.d.). In other words, even the scientific establishment recognizes that the boxes may not map neatly onto the underlying mechanisms.

And please, let us retire the fantasy that the profession has been immune to cultural prejudice. Psychiatry's history includes the classification of homosexuality as a disorder, followed by its removal in 1973 amid changing scientific and professional judgments. Medicine has also too often interpreted women's suffering through paternalistic assumptions. Such episodes do not prove that today's categories are worthless; they prove that credentialed human beings can mistake prevailing cultural judgments for settled scientific conclusions. That should inspire humility, not another round of self-congratulation.

So, when I hear someone explain a child's inattention by saying, "He has ADHD," I want to ask another question. What have you explained? If we identified ADHD because he struggles with attention and impulsivity, repeating the label is not a complete account of why this particular boy struggles. What is happening in his sleep, his classroom, his family, his development, his nervous system, his relationships? A diagnosis can be accurate and still leave the most important clinical questions unanswered. A child is not a billing code with sneakers.

Congratulations, Colleagues! We've Labeled the Child. Now What Happens?

There is something almost magical about a psychiatric diagnosis. A child walks into a classroom on Monday as a complicated, occasionally exasperating, wonderfully unpredictable human being. By Tuesday, somebody has added four letters to his educational record, and suddenly the adults are looking at him differently. Same kid. Same brain. Same outrageous sense of humor. But now he has a label, and apparently that changes things.

I wish I were exaggerating. Unfortunately, the research suggests that this phenomenon deserves considerably more attention than we have given it.

Franz et al. (2023) conducted a meta-analysis of 60 experiments involving 8,295 participants and found that diagnostic labels were associated with more negative evaluations of students, with an overall effect of Hedges' $g = -0.42$. That is a meaningful shift in adult judgment. The children did not suddenly become less intelligent, less capable, or less promising. What changed was how they were perceived. Think about that for a moment. We can alter an adult's impression of a child without changing a single thing about the child himself. Just add a diagnosis.

And before we clinicians begin polishing our credentials and assuring ourselves that trained professionals would never fall for such nonsense, consider Ohan et al. (2011). Teachers and education students evaluating children with ADHD symptoms responded differently when the ADHD label was attached. They perceived greater impairment, experienced more negative emotions, and expressed less confidence in their ability to work with the child. Interestingly, they were also more willing to provide interventions.

Well, isn't that a hell of a bargain? We may have opened the door to services while simultaneously convincing the adults standing in that doorway that the child is more difficult than they previously believed. The diagnosis becomes both a ticket to assistance and a potential invitation to underestimate the passenger.

And lest anyone think I am standing outside the profession throwing rocks, let me confess something. I have been part of this machine, too. I have assigned the diagnoses, written the reports, recommended the interventions, and occasionally become so absorbed in identifying what was wrong that I may not have paid enough attention to what was wonderfully right. I wish I could claim innocence. I cannot. After four decades of doing this work, I have earned enough gray hair to start questioning some of the things I once accepted with considerably more confidence than they deserved.

Now, science is rarely courteous enough to give us a perfectly tidy story, and I have no intention of pretending otherwise. Kashikar et al. (2026) found that learning-disability labels could lower certain teacher expectations and influence educational recommendations, although the wording of the label also mattered and could encourage support. Klapproth and Brink (2024), examining school-track decisions among 46 practicing and prospective teachers, found no statistically significant effect of an ADHD diagnosis. These findings remind us that labels do not operate like some universal psychological curse. Their effects depend on context, the particular diagnosis, the decision being made, and the people interpreting it.

But that complexity should make us more thoughtful, not more complacent.

Here is what bothers me after four decades of sitting with children, parents, teachers, and mental-health professionals. We sometimes confuse understanding what a child struggles with today with deciding what that child will never be capable of tomorrow. Those are two very different things. One is good clinical practice. The other is a potentially devastating prediction masquerading as a diagnosis.

A boy struggles to concentrate, so we appropriately identify ADHD. Wonderful. Now what? Do we investigate what helps him concentrate, what captures his imagination, and what circumstances bring out his competence? Or do we quietly begin lowering the bar because, after all, he has ADHD?

A frightened girl receives an anxiety diagnosis. Does that become the beginning of learning courage, emotional regulation, and the capacity to face difficult situations? Or does every uncomfortable experience now require another accommodation, another exemption, another carefully negotiated retreat from ordinary life? Some accommodations are essential, and genuine impairments demand serious attention. But support should not automatically become a permanent declaration of what a child will never be able to accomplish.

And somewhere in this process, the child is listening. He hears the conferences, the explanations, the worried conversations in the hallway. He notices when adults stop asking what he wants to become and begin discussing what he probably cannot manage. Eventually, the most consequential label may not be the one written in his medical record. It may be the one he begins writing into his own understanding of who he is.

That is the danger I want us to take seriously. Not that diagnoses are inherently harmful, or that teachers and clinicians are conspiring to diminish children. Most are trying desperately to help. The danger is considerably more subtle: compassionate adults can become so preoccupied with protecting a child from difficulty that they inadvertently begin protecting him from discovering his own competence.

So here is a question I would like attached to every diagnostic evaluation, right beside the codes, recommendations, and beautifully formatted clinical impressions: What might this diagnosis cause us to stop expecting, stop noticing, or stop believing is possible?

Because somewhere beneath that collection of symptoms may be a future engineer, an extraordinary teacher, a gifted musician, a loving parent, or simply a decent human being who has not yet discovered what he can do. And I would hate to think that the very professionals entrusted with helping that youngster flourish were the first people to start writing limitations into a future that had barely begun.

A diagnosis should help us understand the obstacles. It should never give us permission to stop looking for the possibilities.

The diagnostic language we use does not arrive in a cultural vacuum, freshly sterilized and untouched by human assumptions. Watters (2010), in *Crazy Like Us*, argued that American mental-health concepts and treatment narratives can reshape how distress is understood in other cultures. His reporting invites an uncomfortable question at home: What stories are we handing our own children about suffering and recovery? Before congratulating ourselves on giving a youngster the right vocabulary, we might ask whether that vocabulary leaves room for a future larger than the symptoms.

A white coat does not confer immunity from ideology. Neither does a doctorate; mine has yet to produce that particular miracle. Professionals bring assumptions about normality, identity, family, autonomy, suffering, and treatment into the room. Some are well grounded. Others deserve a vigorous cross-examination. When a fashionable narrative becomes more important than discovering what is happening with this child, the adults have changed the subject to themselves. Children are not supporting characters in our political dramas, exhibits for our cultural crusades, or opportunities to polish a professional reputation.

Nor am I interested in sneering at adolescents who find comfort in a diagnostic community. When life hurts, belonging can feel like oxygen. My criticism is directed at adults who mistake recognition for the whole job and affirmation for a complete developmental plan. If every conversation celebrates how wounded a child is, who is noticing when that child becomes stronger? A community should have room for progress without making a young person feel that getting better means surrendering the membership card. We owe children affection that does not depend on their remaining unwell.

And Here Comes the Prescription Pad

Now we arrive at the prescription pad, where fifteen years of human complexity can be reduced to “take one daily.” Pharmaceutical marketing would have us admire the efficiency. I would prefer that we meet the child first. Appropriate medication can relieve terrible suffering and sometimes save a life; I have seen it help, and I want children to have access to it. But identifying a diagnostic category should not be the starting pistol for a race to the pharmacy. Before we send a family home with a prescription, somebody needs to investigate the sleep, trauma, learning difficulties, family relationships, developmental history, and circumstances surrounding the symptoms. Otherwise, we risk medicating the alarm while remaining remarkably incurious about what keeps setting it off.

Of course, curiosity takes time, and time is apparently the one therapeutic ingredient the system cannot afford. I have worked in settings where a clinician gets fifteen minutes to address what took fifteen years to develop, while the electronic record demands enough documentation to support a lunar landing. The child has a complicated life; the software has six boxes and an overdue signature. Guess which one starts flashing red? Thoughtful physicians and psychologists get squeezed into this machinery, then judged on whether they keep it moving. We have built an assembly line, hung a “personalized care” banner over it, and left conscientious clinicians trying to practice medicine between conveyor belts.

And the pharmaceutical industry? Please, spare me the image of a compassionate scientific angel fluttering above the examination room. Drug companies sell products. That does not make their products useless, but it does give us reason to distinguish a scientific explanation from a sales pitch wearing a lab coat. Watters (2010), examining depression narratives and commercial promotion in Japan, described how the language used to explain suffering could become entangled with efforts to expand a medication market. He did not establish that pharmaceutical companies invented depression. He raised a more uncomfortable question: how much of what people come to believe about their distress has been shaped by someone with something to sell them? The brochure may discuss your child’s well-being with exquisite tenderness. Somewhere else in the building, people are discussing market share.

A medication can work, a company can profit, and a child can still receive an assessment that leaves far too much unexplored. Those realities can coexist. What deserves our skepticism is the seductive little sequence in which a complicated problem receives a tidy name, the tidy name suggests a tidy chemical answer, and everybody gets to feel that understanding has occurred. Meanwhile, the bullied child returns to school, the exhausted teenager returns to another night without adequate sleep, and the frightened youngster returns to the circumstances nobody had time to ask about. The prescription may help. It cannot interview the family, call the school, or discover the part of the story the child has been too ashamed to tell.

So yes, give me good medications when they are warranted. Give me careful prescribing, honest discussion of benefits and risks, and follow-up that amounts to more than checking whether the bottle needs refilling. But give me clinicians who remain inconveniently interested in the human being after the diagnosis has been entered and the prescription sent. A child deserves more than a pill, a label, and a cheerful escort to the checkout desk. When the paperwork is immaculate and the child remains poorly understood, the machinery has succeeded at something. Let us have the decency to ask whether that something was care.

For Heaven’s Sake, Teach the Kid to Cope

Somewhere between the diagnostic checklist and the prescription refill, we seem to have misplaced a fairly important objective: helping children become capable of living. They need to learn how to survive disappointment, repair a friendship, begin an overwhelming assignment, and settle a nervous system that occasionally mistakes an uncomfortable conversation for an approaching grizzly bear. These capacities do not arrive with the next birthday, like

complimentary upgrades to a phone. They develop through teaching, practice, relationships, and adults willing to stay involved when the work gets inconvenient. Yet we can become so accomplished at identifying what is wrong that we leave a child beautifully diagnosed and utterly bewildered by Tuesday. The chart has an explanation for everything. The youngster still has no idea what to do when his best friend stops speaking to him.

That gap ought to bother us considerably more than it does. When children repeatedly escape difficulties without learning how to approach them, avoidance can begin running the household. The assignment feels overwhelming, so it disappears. A conversation might be upsetting, so nobody has it. An ordinary disappointment becomes an emergency requiring a summit of concerned adults, preferably before lunch. Some situations genuinely require protection or a change in expectations; others require patient help tolerating the experience and learning what to do next. Figuring out the difference is part of our job. We should become deeply uncomfortable when a child's world keeps shrinking while the treatment file requires its own filing cabinet. We cannot count every avoided challenge as a therapeutic success simply because everyone was calmer by dinner.

Appropriate medication can make this work possible. It may help a child concentrate, participate, or experience enough relief to begin learning. I welcome that help. But no pill has ever sat beside a teenager and helped him compose an apology to the friend he humiliated. No capsule establishes a workable bedtime routine or patiently teaches a frightened youngster how to approach something difficult. Those jobs remain stubbornly attached to human beings. If we medicate symptoms and neglect the developmental work, we should stop acting surprised when the child still lacks the skills nobody taught. We cannot subcontract the entire business of growing up to a bottle with a childproof cap and then blame the child when the arrangement fails.

Dr. Russell L. Gombosi and I spent roughly 300 pages exploring these complexities in *Building Adolescent Resilience* (Hansen & Gombosi, 2026). We could have saved ourselves considerable trouble if resilience could be purchased on a refrigerator magnet: "Believe in yourself!" Wonderful. Now explain how the terrified ninth grader gets through the school doors on Monday. Building resilience requires understanding development, strengthening relationships, helping children regulate distress, and creating manageable opportunities to discover competence. Encouragement matters, but children also need experiences that give encouragement something to stand on. Confidence becomes more credible when a youngster can look back and say, "That was hard, somebody helped me, and I learned how to do it." Our task is to help make those experiences possible, repeatedly and thoughtfully, rather than shouting inspirational slogans from the comfortable side of the difficulty.

Responsibility belongs in that process, although bringing up the subject can produce the reception normally reserved for someone proposing mandatory chimney sweeping. Expectations must reflect actual capacity. A child with ADHD may need accommodations, coaching, medication, and explicit instruction in executive functioning. A traumatized child may first need safety and trustworthy relationships; a severely depressed teenager may need intensive treatment and protection. Taking those needs seriously requires us to think carefully about the

next attainable step. It does not authorize us to close the file on possibility. “This is difficult for him” should invite a thoughtful plan, not become the ceremonial announcement that nobody will ever ask him to develop that capacity.

I love the expression on a teenager’s face after accomplishing something he had been certain was beyond him. There is surprise, pride, sometimes a grin he tries unsuccessfully to conceal because appearing pleased in front of an adult would apparently violate the adolescent constitution. That moment matters. It may have taken weeks of preparation, several failed attempts, accommodations, and someone trustworthy who refused to confuse a setback with a final verdict. The youngster now has evidence about himself that no lecture could supply. We should be hungry to create those moments. If we can document every symptom to three decimal places but cannot describe what the child is learning to manage, our clinical precision has wandered off without its purpose.

Accommodations can be essential to that progress, and some children will need them throughout their lives. The question is whether the support opens access and helps the youngster participate, learn, and build a fuller life. We need to revisit that question as the child develops, rather than treating last year’s plan as a sacred document nobody is permitted to touch. Barking “try harder” at a struggling child is lazy. So is assuming that removing the challenge completes our responsibility. The harder, more loving work is to understand the difficulty, provide appropriate help, and remain engaged long enough for learning to occur.

I love these kids too much to applaud every retreat and call it compassion. They deserve adults who take their pain seriously without allowing pain to write every rule for the future. Sometimes we must protect them, sometimes we must change the environment, and sometimes we must sit beside them through the uncomfortable business of discovering that they can do more than they believed. That takes judgment, patience, and considerably more effort than issuing another reassuring sentence. But if our care leaves children increasingly convinced that ordinary life is beyond their reach, we owe them more than a gentler explanation of their limitations. We owe them the help, the opportunities, and the steady belief in their development that make a larger life possible.

What Healing Ought to Mean

This is why my clinical work increasingly emphasizes an integrative approach I call NeuroFaith®. After decades of working with children and families, I have very little appetite for asking a complicated human being to squeeze into whatever theoretical box happens to be fashionable this season. I draw from polyvagal-informed approaches to safety and autonomic state, HeartMath® and physiological self-regulation practices, Internal Family Systems concepts, movement, relationships, and questions of faith and identity when they fit the person and family. These give me ways to explore what is happening and help a youngster develop useful skills. And before anyone mistakes the registered trademark for a halo, my framework belongs under scrutiny, too. Research is needed to establish whether or not NeuroFaith® as a complete approach is superior to established treatments. A trademark protects a name; it does not confer

scientific sainthood. I cannot spend an essay questioning everyone else's assumptions and then declare my own theory a sacred wildlife preserve.

What interests me is what happens when the family leaves the office and life resumes its customary refusal to cooperate. Can the teenager recognize that her body is escalating before she sends the text that detonates three friendships? Can the boy notice a protective reaction before it commandeers the evening and takes the entire household hostage? Can parents and children understand what is happening rather than stage another production of the same miserable argument, now entering its seventh triumphant year? These are the places where our clinical ideas have to earn their keep. A treatment plan can receive admiring nods at a case conference and still be practically useless at 7:15 on a school morning. If the family cannot translate our magnificent explanations into something they can actually do, we should examine the explanation before deciding the family needs another lecture.

I also want to know what the child is beginning to believe about herself. Does she see someone who can learn to manage difficult experiences, or someone whose principal qualification for belonging is being unwell? Can she recognize strengths without feeling that doing so somehow discredits her suffering? A young person should not have to keep presenting evidence of brokenness to remain eligible for affection. I want treatment to help her understand her reactions, develop capacities, and discover meaningful ways to participate in life. If we become so absorbed in explaining why she struggles that we forget to help her discover what she can do, we have produced an impressive commentary on the problem while leaving the youngster to live inside it.

Faith, when meaningful to the young person and family, belongs in that conversation. I am a Christian, and I do not leave that conviction in the parking lot so I can pretend to have no beliefs about human dignity. My faith shapes how I understand the worth of the person sitting before me. But children do not owe me agreement with my theology before they deserve my care; the office is not an entrance examination for heaven. I want to understand what gives this particular youngster belonging, courage, direction, and a reason to get out of bed when life is hard. Those questions deserve more than an embarrassed clearing of the throat because they venture beyond the symptom checklist.

We are caring for a developing human being with a heart, mind, body, soul, relationships, and a future still taking shape. Some of the most consequential parts of that life will never fit comfortably into a diagnostic field, and I refuse to treat them as optional extras because the software cannot find a place to put them. The billing system can survive without a dropdown menu for hope. The child deserves adults who remember to ask about it.

Keep the Diagnosis on the Chart. And for Heaven's Sake, See the Child.

If you have reached the end of this essay believing that Hansen wants to abolish psychiatric diagnosis, throw away the DSM, abandon medication, or pretend that mental illness is imaginary, then somewhere along the way we have seriously misunderstood each other. I believe in good diagnosis, thoughtful prescribing, rigorous research, and the extraordinary work of dedicated

professionals who devote their lives to helping suffering children. I have spent much of my own life among them. They are my colleagues, my teachers, my students, and my friends. And I would not trade the privilege of having worked alongside them for anything.

But I have also spent enough years in this profession to recognize that good intentions, impressive credentials, and beautifully constructed treatment plans do not guarantee that we have understood the human being sitting across from us. I know that because I have been there myself.

I wish I could tell you that throughout my career I always saw the child before the diagnosis, always asked the right questions, always understood the family dynamics, and always recognized the extraordinary possibilities hiding beneath the symptoms. I cannot. I have written the diagnostic reports, participated in the treatment conferences, recommended interventions, supervised young clinicians, and contributed to the machinery of modern mental-health care. Much of that work was important, and I believe much of it helped. But I also wonder how many times I was so busy trying to understand what was wrong that I failed to appreciate what was right. How often did I mistake a carefully constructed clinical formulation for a sufficiently complete understanding of a child's life? How many times did I leave a meeting satisfied that we had developed an excellent treatment plan without asking whether we had adequately considered the person who would have to live with it?

Those are not particularly comfortable questions for an old psychologist to ask himself. But perhaps they are precisely the questions we ought to be asking.

There is something about growing older that changes the landscape of your thinking. The hair gets grayer, the professional certainty becomes a little less impressive, and the accumulation of experience begins challenging some of the assumptions you once held so confidently. You remember the children who flourished, sometimes in ways you never could have predicted. You remember the families who struggled despite everyone's best efforts. And you remember those remarkable youngsters who surprised the hell out of you by becoming something far greater than their clinical histories might have suggested.

But there are other children I remember, too. The ones who did not make it. And those memories are considerably harder to carry.

I remember young people whose lives took heartbreaking turns, some eventually landing in prison, some committing terrible acts against others, and some whose suffering ended in the tragedy of suicide. These are not simply unfortunate outcomes to be filed away in a clinical record or discussed at a professional conference. They were children. Children with names, faces, families, and futures that once seemed full of possibility. And although the years have passed, none of those faces have ever left me.

I would be less than truthful if I told you I had made peace with all of that. I have not. There are tragedies I will carry for the rest of my life. And even now, after decades of clinical experience, I sometimes find myself returning to those haunting questions: What did I miss? Was there

something I failed to recognize? Could I have asked a better question, listened more carefully, intervened differently, or somehow changed the trajectory of a young life?

I know, intellectually and clinically, that we cannot control every outcome. Human development is far too complicated, and suffering is influenced by forces that extend well beyond the reach of even the most dedicated psychologist. I have taught that truth to others, and I believe it. But knowing something intellectually does not necessarily quiet the heart. There is a difference between understanding the limits of our responsibility and no longer grieving what might have been.

Perhaps that is one of the harder lessons of growing older in this profession. We carry the victories with gratitude, but we also carry the losses. Those memories do not necessarily mean we failed. They mean the work mattered, the relationships mattered, and the lives entrusted to our care were never merely clinical abstractions. Every child represented a developing human being whose story was still being written, sometimes toward extraordinary recovery and sometimes toward unimaginable tragedy.

I sometimes wonder whether, as I inch a little closer to heaven, I am finally gaining enough altitude to see the landscape differently. Not perfectly, mind you. I have no illusions that age automatically confers wisdom. I have known some spectacularly foolish old people, and I am quite certain I have contributed a few entries to that distinguished category myself. But there is something about the passage of time, the losses we endure, the people we love, and the growing awareness that our own days are numbered that has a way of rearranging what matters.

The things that once seemed enormous begin to shrink. The things we occasionally overlooked become impossible to ignore.

And increasingly, what I see is the child.

Not the diagnostic category, the insurance authorization, the standardized score, or the meticulously documented treatment plan. I see the frightened little boy trying desperately to make sense of a world that has not always been kind to him. I see the adolescent girl whose anger conceals a loneliness she cannot yet put into words. I see the exhausted parents who love their child beyond measure but have become so overwhelmed by the struggle that they have almost forgotten how to enjoy him. And I see the astonishing capacity of young people to grow, adapt, recover, and surprise us when somebody takes the time to discover who they are beneath the difficulties that brought them into our offices.

I have loved working with these kids. Even the ones who drove me absolutely nuts. Perhaps especially those. Their humor, their stubbornness, their tenderness, their capacity for mischief, and their remarkable ability to recover have taught me at least as much about human development as any textbook I have ever opened. And I suspect that some of the most important lessons of my professional life came not when I was explaining something to a child, but when I finally stopped talking long enough to understand what that child was trying to tell me.

So, to my colleagues in psychology, psychiatry, pediatrics, counseling, and education, I offer this challenge as much to myself as to anyone else: let us become a little less enamored with our explanations and a great deal more interested in the lives unfolding before us. Let us diagnose carefully, prescribe responsibly, accommodate thoughtfully, and never confuse identifying a limitation with determining the boundaries of a child's future. Let us ask not only what a youngster cannot yet manage, but what strengths remain undiscovered, what relationships need strengthening, what skills can be developed, and what kind of life our interventions are actually helping that child build.

And let me speak for a moment to my younger colleagues, especially those of you still working toward your doctorates. Over the years, I have had the extraordinary privilege of supervising, teaching, and mentoring many of you. I have watched you wrestle with complicated clinical questions, develop your professional identities, and discover the remarkable responsibility that comes with being entrusted with another human being's suffering. It has been one of the great honors of my career. I have learned from you, admired your dedication, and taken enormous pride in watching you become thoughtful, capable clinicians.

But I have also watched something troubling happen within parts of our academic and professional institutions. I have seen intellectual inquiry become entangled with ideological expectations, sometimes dressed in the language of progress, inclusion, or social responsibility. Worthy aspirations, certainly. But when those aspirations become doctrines that cannot be questioned, something essential to science begins to die. I have watched young clinicians learn which questions are welcomed, which conclusions are fashionable, and which lines of inquiry might invite disapproval. I have seen legitimate analysis treated with suspicion not necessarily because the evidence was weak, but because the questions themselves challenged prevailing assumptions. And I have watched talented young professionals become increasingly careful about what they say, not because they lack intellectual courage, but because they understand the consequences of stepping outside the approved narrative.

That troubles me enormously. A doctoral education should teach you how to think, not merely what to think. It should equip you to examine evidence, challenge assumptions, tolerate uncertainty, and defend your conclusions with intellectual honesty. If a university or training institution demands allegiance to an ideology, whether progressive, conservative, or otherwise, at the expense of rigorous inquiry, it has betrayed something fundamental about the scientific enterprise. We cannot claim to be training independent thinkers while quietly punishing independence.

And sadly, going against the flow can carry a price. Supervisors may scold you. Performance evaluations may become considerably less stellar. Colleagues who once admired your work may begin to regard your questions as threatening, and some may even turn against you. Institutions can become remarkably efficient at rewarding conformity while making life uncomfortable for those who challenge the machinery. I know something about that, too. And I will not insult your intelligence by pretending that standing apart from the crowd is always comfortable, professionally advantageous, or without personal cost.

But neither does disagreement automatically make us right. Courage without humility can become arrogance, and conviction without evidence can become precisely the sort of dogmatism we ought to resist. We must remain willing to be challenged, corrected, and occasionally humbled by people who see the world differently. That is not intellectual weakness. That is intellectual integrity.

So here is what I want to say to every young clinician I have had the privilege of mentoring, and to those I may never meet: never surrender your soul. Do not allow the pursuit of professional approval, institutional acceptance, or a glowing performance evaluation to replace your obligation to think independently and act ethically. Learn the science. Respect your supervisors. Listen carefully to those who disagree with you. But when the evidence, your clinical judgment, and your conscience tell you that something is wrong, have the courage to ask the difficult question. Have the courage to challenge the fashionable explanation. Have the courage to see the child when everyone around you seems preoccupied with defending the system.

Yes, courage. Because sometimes doing the right thing requires considerably more than knowing what the right thing is.

And there is a satisfaction in that which no promotion, professional accolade, or glowing evaluation can quite replace. You may not win the argument. You may not earn the admiration of your colleagues. You may even pay a personal or professional price for refusing to go along. But you can walk away with your head held high, knowing that when it mattered, you had the courage to step away from the machine, think for yourself, and do what you believed was right for the child sitting in front of you. And as the years pass, I suspect you will discover that a clear conscience is worth considerably more than a beautifully polished performance review.

To parents, I offer a different but equally important appeal. Please do not allow a diagnostic report, however sophisticated, to become the definitive biography of your son or daughter. Take the difficulties seriously. Seek excellent care. Advocate fiercely when necessary. But remember the child who existed before the first appointment, before the first questionnaire, before somebody attached a collection of letters to his name. Remember what makes him laugh, what captures his imagination, what brings her joy, and what dreams may still be waiting to emerge. Your child needs your protection, certainly, but also your confidence that growth remains possible, even when the road is difficult and the destination uncertain.

And if an adolescent happens to be reading this, I want to speak directly to you for a moment. I take your suffering seriously. I know that depression, anxiety, trauma, and other psychological difficulties can make life feel unbearably hard. You deserve competent treatment, understanding, patience, and every reasonable opportunity to get better. But please hear something from an old psychologist who has spent much of his life sitting with young people just like you: whatever diagnosis appears in your medical record, it is not the whole story of who you are. It cannot tell us everything about your courage, your humor, your capacity to love, your ability to learn, or the person you may become. There are chapters of your life that have not yet been written, and neither I nor anyone else has the authority to decide how that story must end.

Perhaps that is what four decades of clinical psychology, and a fair amount of living, have finally taught me. Our greatest responsibility is not simply to identify what is wrong, although we must do that well. It is to help another human being discover what remains possible. That requires science, clinical judgment, patience, and sometimes the humility to admit that we do not understand nearly as much as we thought we did. And yes, I will say something that may make a few of my more academically inclined colleagues squirm: it also requires love. Not sentimental indulgence, not the abandonment of professional boundaries, but a genuine and abiding concern for the dignity, worth, and unfolding future of the person entrusted to our care.

I am grateful for the profession that has given me so much, and I remain proud to be a clinical psychologist. But if I could offer one piece of advice to the younger version of myself, the fellow who once carried his diagnostic manuals and professional confidence with perhaps a little too much enthusiasm, it would be this: learn everything you can, use the best science available, and never stop questioning your assumptions. But above all, do not become so impressed with your ability to explain a child's suffering that you forget to marvel at the child.

And despite the tragedies I have witnessed, the mistakes I have made, and the questions that will probably accompany me all the way to heaven, I remain profoundly hopeful. I have seen too many frightened children discover courage, too many broken relationships find healing, and too many young people rise beyond circumstances that once seemed impossible to believe otherwise. Hope is not a denial of suffering. It is the conviction, grounded in both experience and faith, that suffering does not have to have the final word.

If there is one thing I want parents, teachers, and my fellow clinicians to carry away from these pages, it is this: never underestimate the extraordinary possibilities still unfolding in a child's life. We may not know what that youngster will become, and thank God for that. The future has a wonderful way of surprising even those of us who have spent our lives trying to understand it.

Keep the diagnosis on the chart, where it belongs. Then look up, meet the youngster sitting across from you, and remember that his future is still unfolding.

The DSM does not get to raise our children. We do. And when a frightened child looks to us for an understanding of who he is, let us offer something far greater than a beautifully documented account of everything that might go wrong.

Let us help that child discover everything that might still go wonderfully right.

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