

Bad Therapy: Why the Kids Aren't Growing Up

YAML Header

```
title: Bad Therapy - Why the Kids Aren't Growing Up
author: Abigail Shrier
publication_year: 2024
publisher: Sentinel (Penguin Random House)
topics:
  - Child mental health
  - Psychotherapy
  - Parenting
  - Educational psychology
  - Iatrogenesis
  - Social-emotional learning
  - Adolescent development
themes:
  - Therapeutic culture and its unintended consequences
  - Overdiagnosis and overmedication of children
  - Decline in youth mental health despite increased treatment
  - Erosion of parental authority
  - Risks of well-intentioned mental health interventions
  - Independence and resilience in child development
  - The treatment-prevalence paradox
```

PART 1: Book Analysis Framework (Layered Analysis)

1. Executive Summary

Thesis: The expansion of therapeutic interventions in schools, homes, and pediatric care has paradoxically worsened youth mental health rather than improved it. Despite unprecedented access to mental health services, diagnoses, and medications, adolescent anxiety, depression, and suicide rates have soared since the 1950s.

Unique Contribution: Shrier synthesizes research on iatrogenesis (harm caused by medical treatment) with firsthand accounts from parents, teachers, therapists, and young people to argue that the mental health establishment has created a self-perpetuating system that pathologizes normal childhood development while failing to address root causes of distress.

Target Outcome: To convince parents, educators, and policymakers that the current therapeutic approach to childhood is counterproductive and that reducing expert intervention,

restoring parental authority, and promoting independence and risk-taking would better serve youth mental health.

2. Structural Overview

The book is organized in three parts:

Part I: Healers Can Harm (Chapters 1-3) - Establishes the concept of iatrogenesis and its prevalence in psychotherapy - Documents the “treatment-prevalence paradox”: more treatment correlates with worse outcomes - Identifies nine specific mechanisms through which therapy harms children

Part II: Therapy Goes Airborne (Chapters 4-10) - Traces how therapeutic approaches have infiltrated schools through social-emotional learning - Examines school-based mental health surveillance and diagnosis - Analyzes the role of smartphones, surveys, and accommodations in worsening mental health - Critiques the “trauma-informed” framework and its misapplication to normal childhood

Part III: Maybe There’s Nothing Wrong with Our Kids (Chapters 11-12) - Proposes solutions: parental authority, independence, risk-taking, and family connection - Argues that subtraction (removing harmful interventions) rather than addition is the answer

Architecture Function: The progression moves from diagnosis of the problem (Part I) to documentation of how it manifests (Part II) to prescription for recovery (Part III). Each chapter builds evidence through interviews, research citations, and case studies.

Essentiality: All three parts are essential. Part I establishes the theoretical framework; Part II provides the empirical evidence; Part III offers the alternative vision.

3. Deep Insights Analysis

Paradigm Shifts

1. **From “Therapy as Inherently Beneficial” to “Therapy as Potentially Harmful”**
 - Shrier challenges the assumption that talking about problems with a professional always helps
 - Evidence: D.A.R.E. programs increased drug use; psychological debriefing after disasters worsened PTSD symptoms
2. **From “More Treatment = Better Outcomes” to “Treatment-Prevalence Paradox”**
 - Despite 75 years of expanded mental health services, youth mental health has declined
 - This contradicts the expectation that better treatment should reduce disease prevalence

3. **From “Feelings Are Always Valid” to “Feelings Are Unreliable Signals”**
 - Shrier cites research showing that attending to emotions can amplify them
 - Normal emotional regulation requires sometimes ignoring or suppressing feelings
4. **From “Parental Authority Is Harmful” to “Parental Authority Is Essential”**
 - The therapeutic parenting model undermined parental confidence and children’s sense of security
 - Research on authoritative parenting (high expectations + warmth) shows superior outcomes

Implicit Assumptions Being Challenged

1. **Assumption: Childhood should be pain-free**
 - Counter: Moderate stress, failure, and discomfort are essential for developing resilience
2. **Assumption: Experts know children better than parents do**
 - Counter: Parents have decades of intimate knowledge; experts have hours of observation
3. **Assumption: Diagnosis is neutral information**
 - Counter: Diagnosis shapes self-perception and can become a self-fulfilling prophecy
4. **Assumption: Monitoring and surveillance protect children**
 - Counter: Constant observation creates anxiety and prevents development of autonomy
5. **Assumption: Accommodation helps struggling students**
 - Counter: Accommodation prevents practice with difficulty and undermines self-efficacy

Second-Order Implications

1. **The Competence Paradox:** By removing all obstacles and providing accommodations, parents and schools have created young adults who doubt their ability to handle basic tasks. A 16-year-old who has never entered a store alone cannot imagine doing so.
2. **The Empathy Paradox:** Schools emphasizing empathy have become sites of extraordinary cruelty, as students weaponize emotional narratives against peers. Empathy, when focused narrowly, enables injustice.
3. **The Diagnosis Paradox:** Seeking a diagnosis to explain unhappiness often creates the very condition being diagnosed. A child told she has “social anxiety” becomes more anxious in social situations.
4. **The Independence Paradox:** Children given endless choices about trivial matters (what color shirt) are denied choices about consequential matters (whether to walk home), leaving them feeling powerless.
5. **The Medication Paradox:** Drugs meant to alleviate suffering often numb the ca-

capacity to feel, leaving young people as “potted plants”—present but not alive.

Tensions

1. **Between individual and collective good:** Accommodating one anxious student’s needs may harm the learning environment for others.
 2. **Between short-term comfort and long-term resilience:** Removing a child’s discomfort in the moment prevents her from developing the capacity to handle discomfort later.
 3. **Between professional expertise and parental intuition:** Experts claim scientific authority, but their track record suggests parents’ instincts were often correct.
 4. **Between destigmatization and pathologization:** Efforts to destigmatize mental illness by normalizing diagnoses have instead pathologized normal development.
 5. **Between therapeutic language and moral language:** Replacing “you were wrong” with “you’re struggling with impulse control” removes accountability and agency.
-

4. Practical Implementation: 3-5 Most Impactful Concepts

1. Iatrogenesis as a Framework for Evaluating Interventions

- **Application:** Before accepting any mental health intervention for a child, ask: “What harm could this cause?”
- **Implementation:** Parents should demand that therapists, schools, and doctors explicitly discuss risks, not just benefits
- **Impact:** Shifts burden of proof from “prove this helps” to “prove this doesn’t harm”

2. The Subtraction Principle

- **Application:** Rather than adding more therapy, diagnoses, and medications, remove the harmful elements: smartphones during school, constant monitoring, unnecessary accommodations
- **Implementation:** Parents can unilaterally reduce screen time, stop reading school emails about homework, and allow children unsupervised time
- **Impact:** Often produces immediate improvements in mood, sleep, and focus without professional intervention

3. Authoritative Parenting (High Expectations + Warmth)

- **Application:** Set clear rules, enforce them consistently, but do so with genuine affection and respect for the child’s autonomy in non-negotiable areas
- **Implementation:** Stop explaining every rule; stop offering choices about non-negotiable matters; maintain high expectations for behavior and contribution to household

- **Impact:** Research shows this produces the most resilient, happy, and successful children

4. Independence as Mental Health Treatment

- **Application:** Deliberately assign children tasks that involve real risk and real consequences (walking to store, managing money, making mistakes)
- **Implementation:** Start small (age-appropriate errands) and gradually expand the scope; resist the urge to rescue or supervise
- **Impact:** Builds genuine self-efficacy and reduces anxiety more effectively than therapy

5. Resistance to Expert Authority

- **Application:** Politely but firmly decline unnecessary evaluations, diagnoses, and treatments; trust your knowledge of your child
- **Implementation:** When a teacher suggests evaluation, ask: “What specific behavior is concerning?” and “Have you tried X, Y, Z?” before agreeing to testing
- **Impact:** Prevents unnecessary pathologization and keeps decision-making power with parents

5. Critical Assessment

Strengths

1. **Comprehensive Research Base:** Shrier cites peer-reviewed studies, interviews with leading academics, and extensive documentation of school surveys and curricula. The footnotes alone constitute a valuable resource.
2. **Balanced Presentation of Complexity:** While critical of the mental health establishment, Shrier acknowledges that some children genuinely need professional help and that some therapies (like CBT for specific phobias) have evidence of efficacy.
3. **Powerful Use of Narrative:** Case studies of real families (names changed) make abstract concepts concrete. The story of Chloe at Spence School illustrates how therapeutic language enables cruelty.
4. **Addresses Root Causes:** Rather than just criticizing therapy, Shrier traces how parenting changed, how schools adopted therapeutic approaches, and how smartphones altered childhood—providing a systems-level analysis.
5. **Actionable Recommendations:** The book doesn’t just diagnose problems; it offers specific steps parents can take immediately (reduce screen time, assign chores, allow independence).
6. **Intellectual Humility:** Shrier acknowledges the limits of her own knowledge and defers to experts in specific domains (neuroscience, evolutionary psychology, memory research).

Limitations

1. **Scope Limitations:** The book focuses primarily on middle-class, educated families in the United States. The applicability to other socioeconomic groups, cultures, or countries is unclear.
 2. **Survivorship Bias:** Many examples come from families who can afford private school, therapy, and other interventions. The experiences of families without these resources may differ significantly.
 3. **Temporal Specificity:** The book was written during and immediately after the COVID-19 pandemic, which may have skewed perceptions of mental health trends. Some claims about causation (e.g., “therapy caused depression”) may be overstated.
 4. **Limited Discussion of Severe Mental Illness:** While Shrier acknowledges that some children have genuine psychiatric disorders requiring treatment, the book focuses primarily on the “worried, fearful, lonely, lost, and sad” rather than those with bipolar disorder, schizophrenia, or severe OCD.
 5. **Potential Overcorrection:** Some readers may interpret the book as arguing against all therapy and all medication, when Shrier’s actual position is more nuanced (therapy can help in specific cases; medication should be a last resort, not first).
 6. **Limited Solutions for Systemic Change:** While the book offers advice for individual parents, it provides fewer concrete strategies for changing school policies or the mental health industry’s incentive structures.
-

6. Assumptions Specific to This Analysis

1. **That the reader is a parent or educator concerned about youth mental health** and open to questioning conventional wisdom from experts.
 2. **That the research cited is accurately represented** and that Shrier’s interpretations of studies are reasonable (though some experts might dispute specific claims).
 3. **That the “treatment-prevalence paradox” is real** and not explained by increased awareness, changed diagnostic criteria, or other confounding factors.
 4. **That parental authority and independence are desirable outcomes** and that the reader shares Shrier’s values regarding child development.
 5. **That the mental health industry has perverse incentives** (therapists profit from ongoing treatment; schools benefit from mental health funding) that influence recommendations.
 6. **That the book’s critique applies primarily to the “worried, fearful, lonely” cohort** and not to children with severe, treatment-resistant mental illness.
-

PART 2: Book to Checklist Framework (Actionable Procedures)

Critical Processes Extracted from the Book

Process 1: Evaluating Whether a Child Needs Professional Mental Health Treatment

Purpose: To determine whether a child's emotional or behavioral concerns warrant professional intervention or whether they represent normal development that can be addressed through parental guidance, increased independence, or environmental changes.

Prerequisites: - Honest assessment of the child's functioning across multiple domains (school, friendships, family, self-care) - Understanding of what constitutes normal childhood development and age-appropriate emotional variation - Willingness to consider that the problem may be environmental (too much screen time, too much monitoring, too little independence) rather than internal

Steps:

1. **Observe the child's functioning across contexts** (school, home, with peers, alone) before seeking professional evaluation. Does the concern appear in all contexts or only in specific situations?
2. **Ask: "Is this child unable to perform basic functions of daily life?"** (eating, sleeping, hygiene, attending school, maintaining any friendships). If yes, professional help may be warranted. If no, proceed to step 3.
3. **Distinguish between normal emotional variation and disorder.** Sadness after a breakup, anxiety before a test, or anger at an unfair situation are normal. Persistent inability to function despite these emotions may indicate disorder.
4. **Identify whether environmental factors are contributing.** Before seeking diagnosis, try: removing smartphone, increasing outdoor time, assigning meaningful chores, allowing unsupervised time with peers, reducing parental monitoring.
5. **Wait 4-6 weeks after environmental changes before seeking evaluation.** Many concerns resolve once the environment changes.
6. **If seeking evaluation, interview the evaluator first.** Ask: "What are the risks of diagnosis?" "What are the risks of medication?" "What non-medication approaches have you tried?" If they minimize risks or can't answer, seek a different evaluator.
7. **Insist on a prospective, not retrospective, assessment.** The evaluator should observe the child's actual behavior, not rely on parent or teacher reports of past behavior (which are subject to bias).
8. **Get a second opinion** before accepting any diagnosis that will significantly alter the child's self-perception or lead to medication.

Process 2: Protecting a Child from Unnecessary School-Based Mental Health Interventions

Purpose: To prevent schools from pathologizing normal childhood behavior and to maintain parental authority over decisions about mental health evaluation and treatment.

Prerequisites: - Understanding of your state's laws regarding parental consent for school-based mental health services - Willingness to advocate for your child even if it means disagreeing with teachers or counselors - Knowledge of what constitutes appropriate vs. inappropriate school mental health practices

Steps:

1. **Opt out of all mental health surveys.** Schools often use “passive consent” (you must actively opt out). Submit written opt-out requests for your child for any survey asking about mental health, family relationships, or personal beliefs.
2. **Do not allow school counselors to meet with your child without your knowledge.** In many states, counselors can meet with children 12+ without parental consent. Request written notification of any counseling sessions.
3. **Request a meeting with the teacher before accepting a referral for evaluation.** Ask: “What specific behaviors are concerning?” “What interventions have you tried?” “What would success look like?” If the teacher can't answer specifically, the referral may be premature.
4. **Decline social-emotional learning activities that ask children to share personal information.** These activities often serve as screening tools for mental health concerns and can create unnecessary anxiety.
5. **Monitor your child's school emails and communications.** Schools often use group chats to discuss mental health concerns. Request that mental health discussions happen via phone or in-person meetings, not email.
6. **If your child receives a diagnosis or accommodation at school, request documentation of the evidence.** Ask for the specific assessment results, not just the diagnosis label.
7. **Resist pressure to medicate.** If a school suggests medication, ask: “What non-medication approaches have been tried?” “For how long?” “What were the results?” If the school hasn't tried behavioral interventions first, they're not following evidence-based practice.
8. **Revisit accommodations annually.** Accommodations should be temporary supports while the child develops skills, not permanent fixtures. If accommodations are still needed after a year, the underlying issue may not be what was diagnosed.

Process 3: Restoring Parental Authority and Reducing Therapeutic Parenting

Purpose: To shift from the therapeutic parenting model (constant emotional validation, endless explanations, child-centered decision-making) to authoritative parenting (clear rules, high expectations, genuine warmth).

Prerequisites: - Willingness to tolerate your child's temporary displeasure - Confidence in your own judgment about what's best for your child - Understanding that parental authority is not the same as authoritarianism

Steps:

1. **Stop explaining every rule.** Rules don't require justification. "Because I said so" is a complete sentence. Excessive explanation teaches children that rules are negotiable.
2. **Establish non-negotiable rules** about screen time, bedtime, homework, chores, and respect. These are not up for discussion or compromise.
3. **Stop asking children for permission or input on parental decisions.** You don't need your child's approval to set a rule. You don't need to ask, "Is it okay if we have dinner at 6?" You announce, "Dinner is at 6."
4. **Enforce consequences consistently.** If the rule is "no phone at dinner," the consequence is loss of phone. Not a discussion, not a negotiation, not a "consequence" that's actually a punishment in disguise.
5. **Maintain high expectations for behavior and contribution.** Children should do chores not because they're "learning responsibility" but because they're members of the household. Expect them to contribute.
6. **Stop monitoring constantly.** You don't need to know where your child is every moment. You don't need to read their texts or track their location. Trust them until they give you reason not to.
7. **Resist the urge to rescue.** If your child forgets homework, let them face the consequence at school. If they lose their phone, don't buy a replacement. If they fail a test, don't hire a tutor immediately.
8. **Model the behavior you want to see.** If you want your child to handle disappointment gracefully, handle your own disappointments gracefully. If you want them to work hard, work hard yourself.

Process 4: Increasing Child Independence and Risk-Taking

Purpose: To deliberately expand a child's sphere of autonomy and expose them to manageable risks, building genuine self-efficacy and reducing anxiety.

Prerequisites: - Willingness to tolerate your own anxiety about your child's safety - Understanding that small failures in childhood prevent larger failures in adulthood - Commitment

to gradually increasing independence over years, not months

Steps:

1. **Start with age-appropriate errands.** At age 7-8, send your child to a nearby store with a list and money. At age 10-12, allow them to walk to school or a friend's house alone. At age 14-16, allow them to use public transportation.
2. **Assign meaningful household responsibilities.** Not “chores” designed to teach lessons, but actual work that contributes to the household: cooking dinner, doing laundry, yard work, managing a budget.
3. **Allow natural consequences.** If your child doesn't do laundry, they run out of clean clothes. If they don't manage their money, they run out of spending money. Don't rescue them.
4. **Resist the urge to supervise.** Once you've assigned a task, step back. Don't hover, don't check their work, don't offer unsolicited advice. Let them figure it out.
5. **Encourage risky play.** Climbing trees, riding bikes without helmets (in safe areas), building forts, playing with tools—these activities build confidence and teach risk assessment.
6. **Don't prevent all injuries.** Scraped knees, minor burns, and small failures are how children learn. Preventing all discomfort prevents learning.
7. **Gradually expand the sphere of autonomy.** Each year, allow a bit more independence. By age 18, your child should be capable of living independently (or nearly so).
8. **Celebrate competence, not effort.** Don't praise your child for trying hard at something easy. Praise them for accomplishing something difficult. This builds genuine self-esteem based on actual competence.

Process 5: Reducing Screen Time and Restoring In-Person Connection

Purpose: To reduce the mental health harms associated with smartphone use and social media while rebuilding the capacity for in-person relationships and boredom tolerance.

Prerequisites: - Willingness to enforce unpopular rules - Understanding that smartphones are not educational tools but addiction devices - Commitment to modeling phone-free behavior

Steps:

1. **Establish phone-free zones and times.** No phones at meals, in bedrooms, or during family time. No phones before school or after a certain time at night.
2. **Delay smartphone ownership.** The longer you can delay giving your child a smartphone, the better. If they need a phone for safety, give them a flip phone or

basic phone without internet access.

3. **If your child has a smartphone, use parental controls** to limit app access, screen time, and content. But recognize that controls are not a substitute for rules and consequences.
 4. **Create boredom.** Don't fill every moment with activities or entertainment. Boredom is where creativity and self-reflection happen. Allow your child to be bored.
 5. **Prioritize in-person time with peers.** Encourage your child to spend time with friends in person, not online. Facilitate this by providing transportation, allowing friends to visit, and creating a welcoming home environment.
 6. **Model phone-free behavior.** If you're constantly on your phone, your child will be too. Put your phone away during family time and when with your child.
 7. **Don't use screens as a babysitter or reward.** Screens should not be the default activity when your child is bored or as a reward for good behavior.
 8. **Expect resistance and pushback.** Your child will argue that "everyone else has a phone" or "I'll be the only one without." Enforce the rule anyway. This is one of the most important things you can do for their mental health.
-

Process 6: Evaluating and Resisting School-Based Social-Emotional Learning

Purpose: To identify problematic social-emotional learning curricula and advocate for their removal or modification.

Prerequisites: - Access to your child's school curriculum and lesson plans - Understanding of what constitutes appropriate vs. inappropriate SEL - Willingness to attend school board meetings and advocate for change

Steps:

1. **Request copies of all social-emotional learning materials.** Schools often keep these materials from parents. Use FOIA requests if necessary.
2. **Look for red flags:** Activities that ask children to share personal information, discuss family problems, or monitor family members' emotions; lessons that present normal emotions as disorders; activities designed to increase emotional focus rather than decrease it.
3. **Distinguish between character education and SEL.** Character education teaches virtues (honesty, courage, kindness). SEL teaches emotional self-focus. Character education is appropriate; SEL is not.
4. **Attend school board meetings and voice concerns.** Bring specific examples of problematic lessons. Ask: "What is the evidence that this curriculum improves mental health?" (There isn't any.)

5. **Connect with other parents.** You're likely not the only one concerned. Organize a group to advocate for curriculum changes.
 6. **Request that your child be excused from SEL activities.** In many states, you have the right to opt your child out of activities you find objectionable.
 7. **Propose alternatives.** Instead of SEL, suggest: academic rigor, character education, outdoor education, apprenticeships, or community service.
 8. **Document the impact.** If your child's anxiety or depression worsens after SEL implementation, document this and share it with the school board.
-

Process 7: Navigating Medication Decisions

Purpose: To ensure that any decision to medicate a child is made carefully, with full understanding of risks and benefits, and only after non-medication approaches have been exhausted.

Prerequisites: - Understanding of the risks and benefits of psychiatric medications for children - Willingness to seek second and third opinions - Commitment to trying behavioral interventions first

Steps:

1. **Before considering medication, try behavioral interventions.** Increase exercise, reduce screen time, improve sleep, assign meaningful work, increase independence, reduce parental anxiety. Many concerns resolve with these changes alone.
2. **If medication is recommended, ask the prescriber:** "What is the evidence that this medication helps with this specific condition in children?" "What are the side effects?" "How long will my child need to take it?" "What happens if we stop?"
3. **Be aware of withdrawal symptoms.** Many psychiatric medications cause significant withdrawal symptoms if stopped abruptly. This can trap families in long-term medication use.
4. **Get a second opinion from a psychiatrist (not a pediatrician or therapist).** Psychiatrists have more training in medication management and are more likely to discuss risks.
5. **Start with the lowest possible dose.** If medication is necessary, start low and increase slowly, monitoring for side effects.
6. **Monitor for side effects closely.** Weight gain, sexual dysfunction, emotional blunting, and suicidality are common. If side effects are significant, discuss alternatives with the prescriber.
7. **Plan for discontinuation from the start.** Medication should be temporary, not permanent. Discuss with the prescriber: "When will we know it's time to stop?" "How

will we taper off?”

8. **Revisit the medication decision annually.** Is it still necessary? Are there side effects? Could behavioral interventions now replace medication?
-

Process 8: Building Family Resilience Through Connection and Shared Experience

Purpose: To strengthen family bonds and create a sense of continuity and belonging that serves as a buffer against mental health challenges.

Prerequisites: - Willingness to prioritize family time over individual activities - Understanding that family connection is a mental health intervention - Commitment to including extended family in children’s lives

Steps:

1. **Establish regular family meals.** No phones, no screens, no distractions. This is where family culture is transmitted and children learn to navigate relationships.
 2. **Share family stories and history.** Tell your children about their grandparents, great-grandparents, and ancestors. Help them understand that they are part of a lineage that has survived hardship.
 3. **Include extended family in children’s lives.** Grandparents, aunts, uncles, and cousins provide additional sources of support and perspective. Don’t limit these relationships.
 4. **Create family traditions and rituals.** Regular activities (weekly game night, annual camping trip, holiday celebrations) create a sense of belonging and continuity.
 5. **Allow humor and playfulness.** Families that laugh together are more resilient. Don’t take everything seriously. Make jokes, be silly, find humor in difficulties.
 6. **Don’t hide family challenges from children.** Age-appropriately, let them know that all families face difficulties. This normalizes struggle and builds resilience.
 7. **Model resilience.** When you face setbacks, show your children how you handle them. Don’t hide your struggles; show them how you work through them.
 8. **Regularly assess family connection.** Are family members spending time together? Do children feel known and valued? If not, prioritize rebuilding connection.
-

Summary of Symbols Used

- **Critical Path:** This step is essential and should not be skipped
- **Check:** Verify or confirm this step has been completed

- **Warning:** Be aware of potential pitfalls or unintended consequences
 - **Repeat:** This step should be revisited periodically or cyclically
-

Final Section

Suggested Next Step

Immediate Action: This week, remove your child's smartphone (or establish a phone-free time from 8 PM to 8 AM if they need it for safety). Observe what happens over the next two weeks: changes in sleep, mood, focus, and in-person social interaction. This single intervention often produces measurable improvements in mental health without any professional intervention.

End of Analysis